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# **Staff Perceptions of Patient Engagement**

**A qualitative study of staff working within the context of a specialist low secure inpatient unit for people with learning disabilities and complex needs: how they construct patient engagement and what they feel impacts upon this process.**

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To my family and friends who have comforted, consoled and cajoled where necessary and to Kieran who could never know how much I owe him for everything he did to make sure I never gave up.

## **Declaration**

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## **Preface**

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At the beginning of 2004 I started work as a Healthcare Assistant on an inpatient unit for people with mild learning disabilities, mental health problems, challenging behaviour and forensic histories. It was never meant to be anything more than a way of gaining some experience of inpatient services before moving on to a professional training to become a Counselling Psychologist. Almost five years have passed since then and I am still there. Although I did commence my professional training in 2005, I didn't leave the unit, I just switched role! I was given the opportunity to stay on as a Counselling Psychologist in Training, working with clients and their families in one to one and group sessions as well as with the staff to support the functioning of the team as a whole. Both of these aspects of my role within this unit have proved challenging and rewarding in equal parts and the experiences I have had have ultimately informed and guided the direction of this portfolio of work.

Each of the three major sections of this portfolio reflect not only the different areas of expertise required in a Counselling Psychologist; Researcher, Clinician and Reviewer; but also my own personal areas of interest; learning disability, working with teams and systems, attachment theory, personality disorder and psychodynamic psychotherapy. Although these five areas might sound too diverse to come together to create the basis for a coherent portfolio, they are all linked. Perhaps the most obvious link is that of the inpatient unit described above. It was there that I first came into contact with a service for people with learning disabilities and challenging behaviours as well as mental health problems, such as personality disorder. When thinking about the types of family histories that many of the patients on the unit presented with, attachment theory began to take centre stage in my thinking and formulating of their subsequent challenging behaviours and mental health problems. From here it seemed to be a natural progression for me to start using psychodynamic psychotherapy in my clinical work with patients.

It was also there that I became more fully aware that working in teams is sometimes incredibly complex, frustrating and fraught with difficulties. Yet, I also saw that this was not always the case. All of these areas of interest have informed this portfolio and I would like to take this opportunity to outline the aims and objectives of each of the major sections.

## **Section 1: The Research**

The first major section in this portfolio is the research. It comprises the largest part of this portfolio and focuses on one of the areas of interest that I mentioned above; understanding how a multidisciplinary team functions in order to support staff to engage most effectively with patients. This research was most certainly inspired by my experiences of working within the inpatient unit. I witnessed first hand some of the difficulties associated with working in a multidisciplinary team and saw how sometimes the unit appeared to function really well whilst at other times everything on the unit just seemed very different. When things seemed to be working well, the patients were engaged in activities and the “feel” of the unit was more positive, but this was not consistent and I began to consider what might be happening.

When I changed roles from Healthcare Assistant to Counselling Psychologist in Training I had expected there to be differences in the type of work I was carrying out with patients. I had also anticipated that my perspective of the unit and the difficulties of the patients would be subject to change. What I had not expected was the extent of these differences. At times I was struck by how little truly relevant information that the Psychologists and other non-Nursing members of the Multidisciplinary team had about the patients, the day to day running of the ward and the concerns of the Nursing staff. In meetings or in general conversation with colleagues, I became aware that it often felt as though we were talking about different units. In the midst of this were the patients. In ward rounds and handover meetings, the word engagement would come up time and again “X patient engaged well...” “no engagement from Y this week” “try and engage Z in something”. If it felt as though there were two different units (the Nursing and non-Nursing), then how could we know that we all had a common understanding of what was meant by engagement.

With these thoughts and questions, grew the aims of my research; to gain a clear understanding of how staff from different disciplines construct the term engagement and to establish what they feel impacts on their ability to engage patients on the ward. A qualitative paradigm was used to analyse interview data so that a theory could be generated and presented for discussion.

## **Section 2: Professional Practice**

For the professional practice aspects of this portfolio I have chosen a process report which explores a ten minute section of a therapy session with one of the clients I worked with on the inpatient unit. The process report combines a detailed case history and formulation of the difficulties of the client, discusses the theoretical framework used for this as well as exploring the interventions that I made within a ten minute section of a therapy session. I chose this particular process report for inclusion in the portfolio as it presents the case of a lady with mild learning disabilities and personality disorder who I was working with psychodynamically. The process report offers an opportunity for reflecting on the interventions that I used with this client and to consider how those interventions might impact on the therapeutic relationship and the aims for therapy as a whole.

In the process report that I am presenting in this portfolio, matters concerned with the therapeutic relationship are crucial as I explore how we can repair our alliance following a difficult session the week before. The experience of writing this aspect of the portfolio played a large role in advancing my understanding of psychodynamic theory and practice and how it fits with people with learning disabilities.

## **Section 3: Critical Literature Review**

The final section of this portfolio is the critical literature review. When considering a topic for the review I was immediately drawn to attachment theory and I wanted to know more about this in relation to people with learning disabilities. This interest stemmed from a conference that I had attended on attachment theory in modern practice. I had originally attended this with the aim of broadening my understanding of my work with the non learning disabled clients I was working with in an outpatient psychotherapy service. However, during each of the presentations I found that my thoughts were with the learning disabled patients from the inpatient unit. Many of the patients who seemed to exhibit the most challenging behaviours appeared to have the most dysfunctional and troubled family histories. At the time, whilst sitting in the conference hall, it felt as though things were fitting into place and I had some way of understanding the patients' current behaviour in light of their past experiences of early relationships.

But a “Eureka” moment in a conference hall is not a good enough basis for a deep understanding of a subject and so I set about reading and reviewing the literature associated with attachment theory and learning disability. The literature review in section three therefore aims to establish if attachment theory could offer an explanation for the challenging behaviours of some people with learning disabilities.

### **Conclusions**

This portfolio draws together the experiences I have been fortunate enough to have over the past three years of studying and working on placements, as well as the knowledge I have accrued in that time. Each of the three pieces of work presented within this portfolio are reflective not only of my identity as a Counselling Psychologist but also of the choices I have made and the paths I have taken during my time as a trainee.

## **Staff Perceptions of Patient Engagement**

**A qualitative study of staff working within the context of a specialist low secure inpatient unit for people with learning disabilities and complex needs: how they construct patient engagement and what they feel impacts upon this process.**

## **Abstract**

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Recent research has highlighted the importance of involving patients in matters of service structure and delivery. One area of significance that has emerged for patients living in different types of staffed accommodation (forensic, psychiatric in-patient and community learning disability residences) has been the extent to which they are engaged in activities by staff members. However, there has been little consideration of what is meant by the term engagement and whether staff from a range of mental health professional backgrounds construct it in the same way. Little attention has also been given to what staff feel affects their ability to engage patients within the context of a low secure inpatient unit for people with learning disabilities and complex needs. Grounded Theory was used to analyse the data from interviews with seven participants who work on such a unit. Findings suggest that staff from all professional backgrounds construct engagement as a process that is based on building a relationship with a patient, has different levels to it and is an evolving process. Findings also suggested that participants felt their ability to engage patients was impacted by the “System” which they work within. This “System” consists of five main aspects; 1) Separation vs. Integration; 2) Ambiguity/Mystery vs. Clarity/Demystification; 3) Poor Communication vs. Effective Communication; 4) Criticism/Devalued vs. Acknowledgement/Valued; 5) Reaction vs. Reflection. Findings are explored in the light of previous research and implications for theory and practice as well as for service development and delivery are discussed.

## 1.0 Introduction

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### **en.gage.ment** (ɛn-gæjˈmɛnt)

*n.*

1. The act of engaging or the state of being engaged.
2. Betrothal.
3. Something that serves to engage; a pledge.
4. A promise or agreement to be at a particular place at a particular time.
5. **a.** Employment, especially for a specified time.  
**b.** A specific, often limited, period of employment.
6. A hostile encounter; a battle.
7. The condition of being in gear.

The dictionary definition above shows just how many possible meanings the word engagement has within the English language. Yet it is assumed that staff who care for patients have a common understanding of what this term means in relation to their work with patients. The purpose of this research is to gain a clear understanding of how staff working within a specialist low secure inpatient service for people with mild to moderate learning disabilities, challenging behaviours, mental health problems and forensic histories construct the process of patient engagement and what they feel impacts upon their ability to carry out this process. In this chapter I will briefly outline the reasons for the research before clearly stating the argument that I will be presenting throughout this thesis.

### 1.1 Reasons for the Research

Engagement, both in formal therapy and in general daily activities, has been firmly established as a crucial factor in treatment outcome and quality of life for patients residing on in-patient psychiatric and forensic wards and community learning disability residences (Felce, Lowe, & Blackman, 1995). Studies have shown that boredom and a lack of structured activities on high secure forensic mental health units are considered by patients to be one of the biggest causes of aggressive and violent incidents (Lanza, Kayne, Hick, & Milner, 1994; Meehan, McIntosh, & Bergen, 2006). Whilst Jackson & Stevenson (1998) found that whilst in hospital, service users valued time to talk more than any other intervention. Activity level has also been found to be associated with

quality of life outcomes for people with learning disabilities living in community based residential services (Felce, Lowe, & Jones 2002). Despite these findings there appears to be little consensus about what the term engagement actually means; how it is defined, what it entails and whether all staff from differing professional backgrounds mean the same thing when they talk about engagement.

Although the importance of engaging with clients and offering structured activities, along with the emphasis on client-centred care in mental health settings, has been recognised, it would appear that those who spend more time with the clients than any other member of the healthcare team, the nurses (Kirby & Slevin, 1992), are most likely to be involved in matters of indirect patient care (administrative duties, formal observations with individual patients) rather than directly engaging patients (Secker, Benson, Balfe, Lipsedge, Robinson, & Walker, 2004). There has been some attempt made to study various characteristics of nursing and care staff in order to establish possible explanatory factors for the extent to which patients are engaged in activity (Stancliffe & Lakin, 1998; Emmerson et al., 1999b). However, the results have lacked consistency with some suggesting that staff ratio, size of residence and proportion of qualified staff is associated with activity and engagement, whilst others have found little evidence to support this (Felce et al., 2002). Others have proposed that organisational structure, management practices and internal planning procedures are likely to have a strong mediating effect on staff and patient activity levels (Felce et al., 2002).

Another area of research that has been associated with treatment outcome is the effectiveness of the team that the patient is being treated within. In the NHS there is an emphasis on multidisciplinary team working which is meant to ensure that patients have access to input from a range different modalities to increase the chance of a successful outcome. However, it has been found that staff from forensic and acute inpatient units as well as community mental health teams find this to be one of the most stressful aspects of their day to day working. It would seem plausible to suggest that this holds true for all services, but further research would be necessary to ascertain whether this is the case. It is also not clear to what extent, if at all, the effectiveness of team working affects the level at which patients and staff engage and relate to one another in order to achieve successful treatment outcomes.

Even though the body of evidence examining patient activity levels and factors associated with this is growing, there is still a need for more. In particular, the existing research has addressed how patient engagement in activities impacts on their quality of life but it has not addressed what exactly the term engagement means and how staff construct this process in order to be able to offer client centred care. As well as this, the existing literature does not offer a satisfactory explanation for what affects staff ability to engage patients within the context of specialist services for patients who have both a mild to moderate learning disability as well as mental health problems, challenging behaviour and forensic histories.

## **1.2 Research Aims and Arguments**

The proposed research will seek to address this deficiency in the body of evidence and extend the existing knowledge base by examining a specialist mental health in learning disabilities service. I will aim to close some of these gaps in the literature by researching how staff from a range of professional backgrounds working within a specialist low secure service for patients with learning disabilities and mental health problems construct the process of engagement and what they feel impacts their ability to do this. Consequently it is argued that; staff from all disciplines construct engagement as a process of relating to patients in order to work towards setting and achieving goals that have personal meaning for the patient. It is also argued that their ability to achieve this is affected by the level at which the system they are working within functions.

## **1.3 Overview of Chapters**

**Chapter 2** gives a comprehensive review of the literature associated with patient engagement and multidisciplinary working. It outlines what is already known about these areas as well as providing a strong case for the need for further research into the perceptions of staff on the process of engaging patients.

**Chapter 3** details the methodology used in this research. It outlines the evolution of the research from a quantitative to a qualitative endeavour and offers a description of the historical, theoretical and practical nature of grounded theory and situational analysis. It also describes the procedure employed in recruiting participants, conducting the interviews through to analysing the data.

**Chapter 4** presents the results of the analysis of the interview data. It details the main findings of the analysis and offers a model of how staff construct the process of engaging patients and what they feel impacts on their ability to engage patients within the context of the inpatient ward environment.

**Chapter 5** draws together the main findings of this research and outlines the theory generated by it. It explores how these findings relate to the literature reviewed in chapter two and addresses the implications of these findings for service development. The limitations of the research as well as suggestions for further research are also considered in this chapter.

## **2.0 Literature Review**

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In this chapter I will outline the existing body of literature associated with the research aims of establishing how staff construct the process of patient engagement and what they perceive to impact their ability to engage patients within the context of the system they work within. In order to do this, I will review the existing literature associated with the following areas; client-centred care, boredom and engagement in activities, the therapeutic relationship, staff and organisational factors and the social environment of psychiatric wards. During this review I will build a clear case for the need for further research into the perceptions of staff on the process of patient engagement and the factors that affect their ability to provide it.

### **2.1 Client-centred Care**

Patient needs, experiences and expectations have become an increasingly important factor in research into quality of care for clients with mental health problems and learning disabilities. Indeed, government initiatives have carried the message that patients should be placed at the centre of healthcare and that services should be redesigned according to patient needs (Department of Health, 2000; Health and Social Care Act, 2001a). However, it wasn't until the 1970s that the white paper "Better Services for the Mentally Handicapped" (Department of Health, 1971) was published that service managers began to work toward providing a better quality of life for people with learning disabilities (Hollins, 2000). Since the 2001 white paper "Valuing People" (Department of Health, 2001) person-centred planning for people with learning disabilities has taken on particular importance.

Mansell and Beadle-Brown (2004) found that the evidence that person-centred planning had benefits for people with learning disabilities, in terms of better outcomes, was inconsistent. Although there is some evidence from case-studies that suggests that person-centred planning is beneficial (e.g., Certo et al., 1997), a large scale systematic review by Rudkin and Rowe (1999) showed that outcome differences for people receiving person-centred planning were not significant. Mansell and Beadle-Brown (2004) suggested the possibility that this could be due to difficulties in implementing person-centred planning rather than problems with person-centred planning per se. Organisational factors (which will be discussed in more detail in section 2.4) such as

funding arrangements, staff training and supervision could all impact on the extent to which greater individualisation of service organisation and delivery is possible (Mansell & Beadle-Brown, 2004).

It was only with the rise of the user movement in the mid 1980s that the expectations of patients with mental illnesses were investigated (Campbell, 1997). Before this time, service users were considered to be irrational and non-objective as a result of their illnesses and impairments and so were precluded from research studies (Clifford, 1991). Fortunately, advances have been made since this time, but, recent research has found that there are still some areas that require particular attention to be paid to them. Staniszewska & Henderson (2005) examined the results of recent surveys looking at patient satisfaction and experiences and found that a poor conceptual underpinning of the notion of patient satisfaction has led to some inconsistent and possibly misleading findings. The concerns have mainly centred on the fact that patient satisfaction surveys frequently produce very high levels of positive evaluations of a range of services provided, despite the fact that healthcare provision is unlikely to be as consistently positive as some research has suggested (Williams, 1994). This has prompted a second generation of patient satisfaction research which has found that how engaged patients feel in the healthcare system as a whole as well as how they thought the service understood their personal position, have an impact on how satisfied they feel with the service provided (Staniszewska & Henderson, 2005).

Although this research has focused mainly on provision of mainstream healthcare, it is possible that similar findings would hold true for those patients in contact with mental health or learning disability services. The few studies that have been carried out looking at patients involved in the mental health or learning disability services have consistently found that the views of such patients are a valuable indicator of quality within health services (Schroeder, 1988), but that these views have been acted on in an inconsistent manner despite initiatives such as the Working in Partnership document (Mental Health Nursing Review Team, 1994). When patients have been asked their views, many have said that mental health and learning disability services fail them as they frequently feel powerless over aspects of care; of particular importance to many was the lack of provision of regular and reliable activities and outings (Meehan et al., 2006).

## **2.2 Boredom and Engagement in Activities**

The evidence that points towards boredom and patient activity and engagement levels as being important factors in the treatment outcomes and quality of life of patients with learning disabilities and mental health problems, has come from three main areas; research into factors associated with violent and aggressive behaviour on in-patient forensic and psychiatric wards (Secker et al., 2004; Meehan et al., 2006); quality of life research for people with learning disabilities (Emmerson & Hatton, 1994; Felce, 1997) and the work on active support for people with learning disabilities (Mansell, Elliott, Beadle-Brown, Ashman, & Macdonald, 2002). Results from these three different areas of research have found that patient behaviour, treatment outcomes and quality of life can be affected by the level of structured activity and engagement that is offered to patients (Felce et al., 2002; Mansell et al., 2002; Secker et al., 2004; Meehan et al., 2006).

Following the rise of patients' rights movements and sociological changes there was a shift in focus from the notion that medical and scientific advances alone would improve life. The recognition that personal characteristics were involved in aspects of quality of life meant that enhanced quality of life was finally considered obtainable and realistic for people with learning disabilities (Schalock, 2004). There has been a wealth of literature devoted to establishing how such a concept could and should be assessed and this has led to the development of core domains associated with quality of life. Two of these domains described by Felce (1997) as social well-being and productive well-being, include indicators of the range and frequency of social and community based activities and engagement in constructive activities (Felce et al., 2002). Research in community based supported housing services has shown that residents behavioural abilities are highly related to their quality of life outcomes in these two domains (Stancliffe & Lakin, 1998). Residents with higher abilities took part in more social and community activities as well as being more engaged in activities of daily living (Felce et al., 1998; Felce, Lowe, Beecham, & Hallam, 2000).

One way in which improvement in the above two domains of quality of life has been achieved is through implementing what is called "Active Support". Active support, at its core, is based on supporting people with learning disabilities to take part in everyday activities. The emphasis is on helping the person with a learning disability to do

something rather than doing things to or for them. It has been found that this increases people's access to activities that are part of everyday life, such as washing, cooking, cleaning, shopping rather than simply doing "special" activities or days out which can be costly to provide, happen infrequently and do not necessarily promote social inclusion. Active support has been shown to increase levels of independence, social inclusion and choice (Mansell et al. 2002).

Active support broadly consists of four aspects; staff offering opportunities to clients to take part in everyday activities in the home; establishing routines and regular planning by staff of how they will support clients in these activities; staff providing graded assistance to ensure success and reduce the possibility of challenging behaviour and; staff monitoring and recording client progress so that regular client-centred meetings can assess the level of support required for the individual and modifications made as necessary (Mansell et al., 2002). Active support has been shown to increase engagement in meaningful activities and reduce challenging behaviour even in those with more severe learning disabilities. As Mansell and Beadle-Brown (2004) have shown, the extent to which active support is implemented successfully is, in large part, due to the level of support and training that staff are given in order to apply the principles consistently. Consistency of approach has been found to be a crucial factor in the reduction of challenging behaviours and increase in engagement in the learning disability population. This will be discussed further in section 2.5.

It can be clearly seen that active support provides a link between activities and engagement and quality of life outcomes, however, it only looks at people living in community settings and does not take into account in-patient or forensic populations whose access to such activities might be restricted or more dependent on staff to facilitate them. It is probable that a similar association between quality of life and level of engagement in activities would be found in such settings but as yet the research appears to be mainly limited to community based services. Another consideration when examining the involvement of people with learning disabilities in activities is the nature of their presentation and possible challenging behaviours which could limit their access to such activities. This is true for many patients detained under the Mental Health Act (1983) or with forensic histories as their freedom has been deliberately restricted.

Violent and aggressive patients are most likely to suffer from a restriction in the activities open to them, yet qualitative research involving patients on a high secure forensic psychiatric unit and their perceptions of the reasons for aggressive and violent behaviour, found that empty days, boredom and a lack of structured activities to alleviate these, were crucial contributing factors to violent and aggressive behaviour (Meehan et al., 2006). In addition to this, an examination of the social context of violent and aggressive incidents on an in-patient unit by Secker et al. (2004) found that there was almost no evidence to show that staff on duty had been available to spend time with any clients before the reported incidents took place. Furthermore, it would appear that none of the staff on duty had spent any time with the patients who were subsequently involved in incidents (Secker et al., 2004). It would seem plausible when considering the function of the aggressive behaviour that it could be an attempt to communicate a desire for attention and engagement.

It isn't just structured activities that appear to play a crucial role in patient care, but also just being available to talk is seen by patients as a key aspect of treatment (Jackson & Stevenson, 1998). However, despite patients wanting to be engaged and take part in activities, some research has found that patients are unlikely to ask directly and appropriately for the attention they actually want (Jackson & Stevenson, 1998), thus placing the onus of engagement on staff. As discussed above, although patients are unlikely to ask for attention, it is likely that many acts of inappropriate or challenging behaviour are an attempt to communicate a need or wish for attention. What is still uncertain, having evaluated the literature on engagement in activities, is what is actually meant by the term engagement. Despite an extensive search of the literature, I have found no qualitative attempts to explore this construct further.

### **2.3 The Therapeutic Relationship**

The literature so far has been concerned with engaging patients either with practical aspects of decision making about their care or with taking part in activities. What is lacking is an understanding of the processes involved in making it possible to reach these ends and whether the ends are more important than the means. The answer appears to lie in the domain of the therapeutic relationship. There has been much written about the therapeutic relationship both in terms of its importance within the field of formal psychotherapy as well as its position within psychiatric healthcare. Lambert

and Barley (2001) found that when looking at the influencing factors associated with client outcome for therapy, empathy, warmth and the therapeutic relationship were highly correlated with positive client outcome. In 2004 McCabe and Priebe carried out a review of the literature associated with the therapeutic relationship and the outcomes of patients with severe mental illness within psychiatric services. They also found that a more positive therapeutic relationship was associated with better short term and long term outcomes for patients.

Again, much of the literature associated specifically with the therapeutic relationship and people with learning disabilities comes from the psychotherapy domain. Sinason (1992) talks about the difficulties of building a trusting and therapeutic relationship with some people with learning disabilities due to their often traumatic and troubled early relationships that have frequently been punctuated by rejection and disappointment. Due to this, it has been suggested that a loosening of the strict therapeutic stance of neutrality might foster the chance of building a more trusting relationship that could enable psychotherapeutic work to take place. Sinason (1992) warns that loosening the boundaries to include a more friendly, open stance and the possibility of using physical touch at times of heightened distress, should be done with caution. It is easy to see how these steps, although well meaning, could have a less than therapeutic effect. If used without caution, they could be construed as patronising or at worst, abusive, and could have the effect of disempowering rather than empowering this vulnerable group. Another important factor to consider when thinking about the use of touch, in particular with those who present with challenging behaviours, is the possibility that touch could reinforce inappropriate behaviours. If, as considered in section 2.2, that the function of certain behaviours is to gain attention from staff, then physical touch could reinforce the use of such behaviours.

Beyond the world of psychotherapy and learning disability, the literature becomes more sparse. The government guidelines recommend that people with learning disabilities have access to the same standards of care as those without learning disabilities. So, the findings associated with general psychiatry and the importance of the therapeutic relationship should be the same for this population.

Indeed the therapeutic relationship is seen to be crucial to the training of learning disability nurses. Basford and Slevin (2003) in their book “The Theory and Practice of

Nursing” state that building a therapeutic relationship with patients with learning disabilities, coupled with providing a consistent approach (such as using active support) are key to enhancing both emotional and social well being of the patient. It appears to be seen as a key component to the training of nurses both in the field of mental health and learning disability. A search of the various training manuals and handbooks associated with the training of nurses, as well as a variety of other mental health professionals (from Psychiatry to Occupational Therapy) appears to have the building of a therapeutic relationship at its core. Yet, there seems to be a paucity of research into the effect of the therapeutic relationship within services for those with learning disabilities, or with both a learning disability and mental health problems. Despite this gap in the literature, it would seem plausible to suggest that the therapeutic relationship would impact on the treatment outcomes for this client group, but further research is required.

Evidence from mental health nursing research also puts the therapeutic relationship at the forefront of patient care. As far back as the 18<sup>th</sup> century there has been mention of using a relationship with patients as a means of limiting the need for restraint and reducing mental disturbance (Tuke, 1813). Modern mental health nursing also claims to be built on the premise that nurses use themselves as a therapeutic tool (Peplau, 1992). However, it has been noted that despite this ethos of the importance of building a therapeutic relationship with patients within the nursing tradition, the reality can be very different. In Britain, since the deinstitutionalisation of mental healthcare, the development of interpersonal approaches has been uneven (Ritter, 1997). Caine and Smaile (1968) found that whilst those working within therapeutic communities which adopted psychodynamically oriented ways of working continued to develop the use of the therapeutic relationship, those working within more traditional mental health hospitals, emphasized the use of order and control. Although the rise in the user movements, as mentioned earlier, has forced the mental health system to make changes in how care is delivered there are still difficulties associated with nurses being able to fully utilise the therapeutic relationship as the basis of their work (Gijbels, 1995).

Gijbels (1995) found that nurses who worked in an acute psychiatric ward had fewer opportunities for developing their therapeutic and relationship building skills than specialist practitioners (psychologists, psychiatrist, occupational therapists, etc.) working within the same ward. The role of the nurses appeared to be more concerned

with managing the environment, maintaining the safety of patients and staff, escorting patients to therapeutic activities and involving themselves in administrative duties. It appears that although all mental healthcare professionals ascribe to the importance of the therapeutic relationship, the realities of its implementation are varied across disciplines. Those who work in specialist professions have a focus on building therapeutic relationships to facilitate recovery and change, whilst nursing staff appear to have the task of maintaining safety by having a custodial and controlling character (Gijbels, 1995). It would seem that this presents a real polarisation, with the nurses as wardens concerned with safety and control and other professionals concerned more with therapeutic relationships. However, if Nurses were able to find a middle ground, whereby a therapeutic relationship could be built that allowed for a consistent approach to be followed with respect to clear expectations and feedback for patients, then it is possible that improvements in mental health and challenging behaviour could be seen.

Despite this finding, it is unclear as to whether this would hold true for staff working within long stay mental health in learning disabilities inpatient services. It is likely that due to a similar culture within mental health hospital settings, long stay wards would be tied by similar operational policies and government directives, but further research would need to establish whether this is the case. Two things remain unclear; how does this therapeutic relationship enable staff to engage patients in activities and decision making and to what extent does the organisational structure impact upon the ability of all staff to build therapeutic relationships that lay at the centre of treatment for patients within mental health in learning disabilities inpatient services?

## **2.4 Staffing and Organisational Factors**

Aragon & Holmes (1990) found that patients on an in-patient ward for learning disabled and mentally ill patients spent most of their waking day unengaged in day rooms and halls, whilst staff spent the majority of their time in a nursing station involved in aspects of indirect patient care. When we consider this finding in relation to what we know about the importance of activity and engagement for patients and that patients are unlikely to ask for attention or engagement in direct or appropriate ways (Jackson & Stevenson, 1998) then it would appear that factors related to staffing need to be addressed. Secker et al. (2004) found that staff are more likely to be involved in administrative duties, answering phones or engaged in formal observations of individual

patients than actually spending time interacting with and engaging patients. Meehan et al. (2006) found that “staffing problems” often led to the cancellation of planned activities and was a constant source of frustration for patients who looked forward to activities to relieve the boredom.

From the evidence of Meehan et al. (2006) alone it would appear that there is some kind of link between patient activity and engagement and staffing factors. However, what is not clear is what these factors are. Research into the staff who work in psychiatric and learning disability services has focused on several areas; staff stress levels and burnout, job satisfaction, staff to patient ratio, proportion of qualified staff, staff turnover and level of experience and knowledge related to current work. It has been widely acknowledged that staff working in psychiatric services have a high level of burnout and poor mental health (Kilfedder, Power, & Wells, 2001; Edwards & Burnard, 2003) and that staff working with patients with learning disabilities report a higher level of stress and lower levels of staff morale than general health service staff (Borril et al., 1996; Hatton et al., 1997). Lawson & O’Brien (1994) took this one step further and examined how stress levels and self reported burnout in staff could affect patient activity. They found that staff who reported high levels of burn out were less likely to engage in positive client contact than staff who reported low levels of emotional exhaustion (Lawson & O’Brien, 1994).

The ratio of staff to residents in community housing services for people with learning disabilities has been found by some studies to predict activity and engagement (Emmerson et al., 1999b; Felce et al., 2000) but not by others (Stancliffe & Lakin, 1998). Felce et al. (2002) also found that whilst a higher ratio of staff had a positive effect on activities carried out within the community, it also appeared to have a negative impact on activities carried out within the home. Whilst none of the studies have found the size of the setting to influence outcomes of engagement in activities (Emmerson et al., 1999b; Stancliffe & Lakin, 1998; Felce et al., 2000). Another factor that has been shown to have a limited effect on patient activity and engagement is the proportion of qualified staff on duty. Felce et al. (2002) found that this had an effect on resident participation in domestic tasks but was otherwise not shown to be positively associated to activity or engagement level. One other factor that has been thought to mediate between staffing characteristics and their level of engagement with patients is the organisational structure or formal culture of the service (Felce et al., 2002). Clear

operational policies, goals, working methods and training have been suggested as a potential factor for staff engagement as they set out what staff can and cannot do within their role (Felce et al., 2002).

However, the results of these studies have frequently been inconclusive and inconsistent and have led some to argue that interaction effects may be more important than the effect of each individual factor in isolation (Hastings, Remington, & Hatton, 1995). One other important factor associated with staffing is the level of experience and knowledge staff have in relation to their current role. Hollins (2000) has reported that some specialist knowledge is needed in order to provide the highest level of care and to work with people with challenging or mental health needs. Indeed, in order to retain and recruit staff, training and skills development are seen as crucial to providing continuity of care and minimising the problem of high staff turnover (Hollins, 2000).

Hatton et al. (1997) carried out a large scale piece of research looking at the staff who work in services for people with learning disabilities. The findings of this research suggest a poor person-organisation fit leads to poor staff outcomes in terms of overall job satisfaction, stress, morale, absenteeism and intention to leave the service. This suggests that having clear organisational policies and values is crucial in ensuring that a service can recruit and retain staff who fit best with the values of the organisation. Hatton et al. (1997) also found that by increasing staff training in the policies of the organisation and by including staff of all levels in having a say in the way in which the organisation is run, is likely to reduce frustration and objection to implementing policies and procedures and increase the commitment of staff to the organisation. Mansell, Beadle-Brown, Whelton, Beckett, & Hutchinson (2007) found that clear management guidance, frequent supervision, team meetings, training and support were also crucial factors in the extent to which residents were helped to engage in meaningful activities. Whilst these findings all suggest that staffing and organisational factors could impact on staff ability to engage patients in a variety of settings, they focus solely on community based settings for people with learning disability. They do not specifically address inpatient psychiatric services for people with learning disabilities.

The area of job satisfaction in healthcare workers has been widely researched; however, what is meant by job satisfaction is often unclear. Specter (1985) describes job satisfaction as:

*“an emotional response to a job or specific aspects of a job which are derived from a cognitive process of comparing an individual’s frame of reference with the existing job aspect.”* (Spector, 1985, p.695).

Job satisfaction has been found to correlate with leadership style, pay, staff absenteeism and turnover and withdrawal behaviour and intention (quitting the job) (Spector, 1985). When one takes into account that staff working in psychiatric services have a high level of burnout and poor mental health (Kilfedder et al., 2001; Edwards & Burnard, 2003) and that staff working with patients with learning disabilities report a higher level of stress and lower levels of staff morale than general health service staff (Borril et al., 1996; Hatton et al., 1998), it would seem plausible to suggest that the job satisfaction of these staff would be affected.

Hatton et al. (1999) found that staff working with clients with learning disabilities associated the following factors with work satisfaction; stress from low status (pay) job, support from colleagues and immediate supervisors and having influence over decisions at work. Similar factors have been found to associate with job satisfaction in staff working with people with learning disabilities by Hatton & Emerson (1993b), Razza (1993) and Dyer & Quine (1998). These factors not only affect the staff and their job satisfaction, but have also been found to have a knock-on effect for the service users these people are caring for. In particular, high levels of staff turnover, poor staff morale and poor job performance have been found to have an impact on service users’ welfare (Rose, Mullen, & Fletcher, 1994). With these findings in mind, it would seem that job satisfaction plays an important role not only in terms of how staff feel about their work, but would also appear to reflect how effective the organisational structure is at providing adequate support, supervision and opportunities for staff to feel valued (by means of promotion opportunities and influence over decisions at work).

Whilst these findings appear to hold true for staff working with people with learning disabilities in community based settings, there has been little research into staff working with clients with both learning disabilities and mental health problems within the context of a low secure in-patient environment within the NHS. Such settings are subject to a variety of policies and procedures that are often generated by centralised committees and not necessarily by those working within a specific ward. This is one area that needs to be addressed before it is possible to establish if staffing and organisational factors play a similar role in such settings. What is also crucial to note is

that much of the research into both staffing and organisational factors have focused more on one set of professionals and how they fit within an organisation; the nurses and care staff. There have been few studies looking at the effects of multidisciplinary working within long term low secure mental health in learning disability services. There have, however been several studies that have assessed the nature of team working within multidisciplinary teams in community mental health, acute inpatient psychiatry and forensic inpatient psychiatry. West (1994) defined team effectiveness as being concerned with team reflexivity, social reflexivity, task effectiveness and mental well-being of the team. Team reflexivity is the ability of the team to focus on aims and objectives through evaluation and feedback mechanisms. Social reflexivity is how much support there is within the team for individual members. Task effectiveness is measured by the outcomes in relation to the aims and objectives. The mental well being of the team is considered to be the extent to which the growth and development of individuals is promoted.

These four aspects could then be used to judge the effectiveness of the teams. Another theory that has also been used to understand the nature of team working is the theory of cooperation and competition (Deutsch, 1949). This theory states that people in groups perceive their own and others goals as either cooperatively linked or competitively linked. Those who view the outcome of their goals as cooperatively versus competitively linked are more likely to have trust in team members, experience psychological safety and benefit conflicts both as an individual and a team due to the constructive way in which it is handled (Wong, Tjosvold & Yu, 2005). Within mental health inpatient settings there are a range of staff from a variety of different professional backgrounds often working with the same patients to achieve good treatment outcomes. However, although there is a tacit understanding that all professionals are working together, the reality is often far more complex.

Brooker and Whyte (2001) found that across all professional groups and all levels of security, the pressures of multidisciplinary working were the most frequently cited source of difficulty. Despite this, there is recognition that providing a range of treatment options to patients via a multi team approach has benefits in terms of treatment outcomes (Lieberman, 1992). Although these studies into team effectiveness have ascertained that there are links between the effectiveness of the team working and the treatment outcomes of patients, they do not specifically look at the effect that team

working has on engaging patients. It is plausible to suggest that staff and patient engagement with a poor functioning team which has ambiguous goals and erratic communication, would be negatively affected but further research would be necessary to establish if this were true.

## **2.5 The Social Environment**

The final area of research that I wish to consider in relation to patient engagement pertains to the social environment of the ward. Despite the fact that behavioural theories of psychology are based on the concept that behaviour is a function of the person and their environment, the atmosphere in which psychiatric patients were cared for was a dimension that was generally overlooked until the 1960s. At this time Moos & Houts (1968) developed their scale to measure the social atmospheres of psychiatric wards; the Ward Atmosphere Scale. Before this time, research into treatment outcomes and patient behaviour were mainly centred on studies of the person out of context with their environment (Moos & Houts, 1968). However, since the inception of the Ward Atmosphere Scale, a considerable body of research into the effect of ward environment on treatment outcome and staff and patient satisfaction has emerged. The Ward Atmosphere Scale (WAS) is a self report questionnaire that measures the quality of an environment by describing 10 subscales grouped into 3 dimensions: (1) Relationships; involvement, support, spontaneity. (2) Personal growth; autonomy, practical orientation, personal problem orientation, anger and aggression. (3) System maintenance; order and organisation, program clarity, staff control.

The social environment of the ward has thus become an established dimension in patient treatment outcomes (Eklund & Hansson, 1997) and as such, measures of ward atmosphere have been used to assess the evolution of therapeutic environments for psychiatric patients and improve the environments accordingly (Smith et al., 1996). The atmosphere of long stay mental institutions was the initial focus of early research (Kellam, Goldberg, Scholer, Berman, & Schmeltzer, 1967; Moos & Houts, 1968;), but since healthcare reforms have meant the closure of such institutions, the research has continued in other mental health settings. The social environments of acute in-patient psychiatric hospitals, medium and high secure forensic psychiatric units and long stay residential and group homes have all been measured and found to be crucial to patient outcome and satisfaction.

Much of the research carried out on ward atmosphere has taken place on short stay acute inpatient wards for patients with a diagnosis of schizophrenia. Wing and Brown (1970) found that under-stimulating, rigid and impersonal hospital environments had an adverse affect on treatment outcomes, whilst improvements in the treatment environment showed beneficial clinical results. Wing (1978) also reported that patients with schizophrenia require a carefully planned environment in which their symptoms may be minimised and where healthy living and social behaviours are possible. The social environment of the ward has not only been found to have an affect on treatment outcome for the duration of the inpatient admission, but also once the patient has been discharged back to community settings. Klass, Grove, and Strizich (1977) found that when patients had stayed on a ward that was high on order and organisation and low on anger and aggression, on discharge, they maintained a longer period in the community without relapse than patients who had not. These findings were confirmed by Friis (1986) in his study of 35 short term wards. He found that psychotic patients seem to benefit from an environment that had a high level of support, practical orientation and order and organisation and a low level of anger and aggression (Friis, 1986). However, although this body of evidence does appear to be useful in determining beneficial treatment environments, it only does so for one distinct population of people with mental health problems; those with a diagnosis of schizophrenia. Another important point to note is that although these studies appear to suggest the existence of a causal relationship between ward atmosphere and the success of patient outcome on discharge from hospital, further evidence would be required before this could be reliably established.

There has, however, been a limited amount of research conducted on mixed populations (where the patients do not all have the same diagnosis and less than one third have a diagnosis of schizophrenia). Most notably, in the study mentioned above, Friis (1986) found that on such wards, the patients appear to benefit most from an environment that includes high levels of involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, order and organisation and program clarity, low levels of staff control and intermediate levels of anger and aggression. Although this gives us further insight into how the treatment environment might affect different patient populations, it still does not give us a definitive set of guidelines for all patient populations. For example, it does not explore how patients with a mild to moderate

learning disability, challenging behaviours, mental health problems and some forensic histories, might be affected by the atmosphere of the ward in which they are residing. Despite an extensive search of the literature, it would appear that there have been no studies into the most beneficial environment for such a patient population.

As Schalock and Felce (2004) have cited, the environment in which people with intellectual disabilities live as one of the key domains for quality of life outcomes it could be proposed that the ward atmosphere would be of particular importance for these clients. This can be suggested following evidence that has highlighted the salience of a number of physical environmental factors, such as noise, temperature, location, crowding, as potential mechanisms that may impact on challenging behaviour (Kennedy, 1994; Matson & Mayville, 2001). Factors including the interpersonal setting, which covers relationships and values, as well as the organisational setting (systems and processes in place to support the individual), have also been shown to be key environmental aspects that can affect challenging behaviour (Hastings, 2002). Behavioural studies have long since noted that common functions of challenging behaviour are social contact and social avoidance (Emerson, 2001). As many of the sub scales of the WAS overlap with the environmental factors described above, it would seem probable that a more therapeutic setting (as defined by the WAS), where there were good opportunities to build relationships and where there were clearly understood aims that allow both staff and patients to work towards a common goal, would result in less challenging behaviour and better quality of life outcomes. However, further research would need to be carried out before such a conclusion could be reached.

Following the work of Friis (1986) most of the research on ward atmosphere has focused less on the effect the ward atmosphere has on patients and more on how the ward atmosphere differs between service types (e.g., medium secure settings versus low-secure settings), longitudinal studies of the evolution of therapeutic environments and how perceptions of the ward atmosphere differ between staff and patients. In respect of the first set of studies looking at how ward atmospheres differ across settings, it was thought that patients residing on psychiatric wards with different levels of security (low, medium and high-secure) would report significant differences in their perceptions of the ward atmospheres. However, most have found there to be no significant difference between settings (Kirby and Pollock, 1995; Kirby, 1997) and despite the different levels of security imposed on patients, the treatment environments

appear to remain therapeutic. These findings would appear to suggest that a therapeutic atmosphere can be attained for any ward regardless of its type, however, the search of the available literature showed that this has yet to be made explicit by researching all ward settings, in particular specialist inpatient services for people with a mild to moderate learning disability, challenging behaviours, mental health problems and some forensic histories.

As mentioned above, longitudinal studies have provided some information on how it is possible to create a therapeutic environment; however, there is still a paucity of research in this area. Smith, Gross, and Roberts (1996) carried out a study into how the introduction of a therapeutic rehabilitation plan affected the ward atmosphere on a long-stay ward for patients with schizophrenia as the most common diagnosis. They found that through the implementation of this programme, the treatment environment was rendered more therapeutic (Smith et al., 1996). Rossberg, Melle, Opjordsmoen, and Friis (2006) found similar results when changes in ward atmosphere scores were correlated with patient satisfaction scores. They found that increased patient satisfaction was associated with more therapeutic ward atmospheres (Rossberg et al., 2006). These findings are encouraging and appear to suggest that it is possible to change the ward atmosphere and make it more therapeutic and satisfactory for patients, however, caution must be urged when suggesting a causal effect of ward atmosphere on patient satisfaction; it could be that more satisfied patients are more likely to perceive the environment as therapeutic rather than the environment making them more or less satisfied.

Finally, the question of how staff and patients perceive the ward atmosphere must be addressed. There has been some debate as to whether staff and patients perceive the ward environment in different ways. One would expect there to be differences in certain sub scales of the ward atmosphere scale for staff and patients, indeed, Brunt & Rask (2005) and Rossberg & Friis (2004) both found this to be the case. Both found that patients and staff differed on all but two of the sub scales, however, the findings did not agree on which of the sub scales differed (Brunt & Rusk, 2005; Rossberg & Friis, 2004). It is possible that as both studies were conducted in different service settings (maximum secure versus short stay acute wards); the subscales might be rated differently. Although these findings appear to suggest a difference in patient and staff perceptions, caution must be urged when generalising the results. They represent two

very distinct settings and findings might not be the same across all the available psychiatric settings. Indeed, Schjodt, Middleboe, Mortensen, and Gjerris (2003) found that overall, staff and patient perceptions of the ward atmosphere across four separate psychiatric wards (from open to secure services) were in agreement about the valuations of the treatment environment. It would appear that there has been no general consensus reached on whether a difference between staff and patient perceptions of the ward atmosphere actually exists or whether it varies from ward to ward.

From the research into the social environments of psychiatric wards it can be seen that there are some factors associated with more therapeutic environments. Many of these factors are linked to the extent to which there are opportunities to build relationships with both staff and peers, how clear the aims of the programme (ward ethos) are to both staff and patients alike and how much practical support was available to patients. Although the work into social environments incorporates a wide range of well established constructs associated with both organisational and individual factors relating to treatment outcome, it does not offer a full account of how the process of engagement is specifically addressed within this framework. An extensive search of the literature also appears to suggest that a qualitative exploration of ward atmosphere and the factors associated with this and specifically how this impacts upon patient engagement, has not been attempted.

## **2.6 Conclusions**

From reviewing the literature in the five areas of client centred care, boredom and engagement in activities, the therapeutic relationship, staffing factors and organisational factors and the social environment of psychiatric wards, it can be concluded that further research is necessary to increase our understanding of patient engagement. In particular, whilst there have been some associations made between the patient activity levels, organisational factors and the social environment of psychiatric wards, there is a paucity of research aimed at establishing a deeper understanding of what is meant by patient engagement. There is not only a need to gain insight into how staff from all mental health professional backgrounds construct the process of patient engagement but also to explore what they feel impacts upon their ability to engage with patients. The research base could also be increased by gaining a better understanding of how complex situational or organisational factors impact upon engagement. Due to this, I will aim to

close some of these gaps in the literature by researching how staff from a range of professional backgrounds working within a specialist low secure service for patients with learning disabilities and mental health problems construct the process of patient engagement and what they feel impacts their ability to do this.

### **3.0 Methodology**

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In this chapter I will describe the evolution of this piece of research from a quantitative to a qualitative paradigm. I will then clearly describe the historical and theoretical underpinnings of grounded theory and situational analysis and why this method of collecting and analysing qualitative data fits with my research aims. Following this, the practical aspects of situational analysis will be examined in detail before moving on to considering issues of rigour within the qualitative paradigm and how I have addressed them within my own research. The ethical and political implications of this piece of research will also be discussed before finally summarising the procedure used for data collection and analysis.

#### **3.1 From Positivism to Postmodernism**

Philosophy is a major component of the research process. It directs the way in which you view research and its findings along with the kind of questions you want your own research to address, the manner in which you set about collecting data and the subsequent method you will use to analyse this data set. In that case, how and why does one researcher move from a positivist search for a universal and generalisable “truth” to a post-modern stance that favours the notion of complexity over simplification and that all knowledge is socially and culturally situated (Haraway, 1991b)-there are no universal “truths”? It has possibly been driven by the conflict between an ongoing desire to find absolute answers to concrete questions and an emerging realisation that life just is not that simple, but, in a truly post-modern way, it is probably a lot more complex than that alone.

This piece of research started out as a quest for the truth, an answer to the burning question; is the nature of the social environment (the atmosphere) of an NHS inpatient psychiatric unit related to how staff view their levels of job satisfaction? Having worked on one psychiatric inpatient unit for some years in two different guises (Healthcare Assistant and Counselling Psychologist in Training) I was privy to the day to day working of the unit from two entirely different perspectives. This difference struck me as strange, after all, the nursing and psychology teams both work on the same ward with the same patients and the same end goals in mind as far as patient outcome is concerned-why is it so different? The answer seemed to come from my experience of

working directly on the ward and the many times I had spoken to nursing staff about their levels of job satisfaction, pay, level of autonomy, grumbles about “Management” and so on. It seemed to appear that those who were most negative about their job satisfaction were also more likely to talk about difficulties arising from working with other disciplines, were less motivated to engage patients in activities, thus leading to both staff and patient boredom and a whole range of negative outcomes; poor morale, increased sickness and absenteeism, increased staff turnover and poor patient outcomes.

The best route to finding the answer to this question once and for all seemed, at the time to be best achieved by gathering data from a large number of participants drawn from their answers to three questionnaires. After all, I was in search of a rational and generalisable truth that could give me a fairly definitive answer. All of this work was fixed in the notion that there was a reality out there that held true for all, an answer to the question that I was posing and that I could be naively objective despite the wealth of information and ideas that I already possessed having worked within the particular organisation for some years. Looking back now, I can clearly recall the moment that I began to wonder about whether there was one answer to the question I wanted to be answered or whether I had known all along that it was more complex but had somehow wanted to “bury my head in the sand”. Until this point I had felt somewhat detached from my research and as if it had very little to do with what I actually wanted to find out. That somehow, in the process of looking for answers I no longer knew what it was I was really asking.

When the questionnaires that I had circulated, advertised and tirelessly promoted yielded almost no response, I had to think, was this just the usual apathy or was this something else? Was I completely “barking up the wrong tree?”, had I completely misjudged the mood of those working on the ward?, or was it that I was going about things in the wrong way? Was there something, other than apathy, that was underlying people’s silence? The answer to these questions came from many sources; that people still continued to approach me and talk about difficulties they were having on the ward and problems that they felt were contributing to these difficulties, the concerns that many staff approached me with about having to supply true or false answers to a series of questions which they felt did not give the chance to explore key areas further, plus, the comments that I received that appeared to suggest a level of uncertainty and fear

about how the responses they gave would be used-especially concerning job satisfaction.

It seemed that no amount of reassurance that the results were anonymous, confidential and would not affect their job security in way, was not enough. So, there seemed to be some paradoxes to contend with; staff had maintained their silence by not participating in the research but continued, informally, to give voice to many of the dimensions the research hoped to access. Those who had taken the opportunity, wanted to explore the intricacies of their responses further. Even those who were fearful about how their responses would be used when it came to the job satisfaction surveys, appeared un-phased by the thought of talking freely about this and other aspects of life on the ward, when broached with the idea of doing an interview with me instead. Of course, these could all just have been ways of placating me, but it seemed that I had judged the mood of the ward and its staff correctly, but misunderstood the question that I should be asking and how I should go about researching it.

It seemed that the only way forward now, was to return to the origins of this research-listening to the staff and trying to interpret what they were saying into a theory instead of trying to make them fit into a theory that already existed. At the same time that this next phase of the research was evolving, I “found” a method that seemed to fit completely with me and the research that I was trying to carry out-Grounded Theory. In particular, an evolution of the original grounded theory which took into account the situation of the research as well as the people working within it-Situational Analysis. Before it is possible to describe the processes involved in this, it is necessary to explain how it came to exist, where it lies both theoretically and epistemologically.

### **3.2 Grounded Theory and Postmodernism**

Grounded Theory has its roots in the positivist world of 1960s America. The original works of Glaser and Strauss (1967) sought to provide a means of empirically studying social life via qualitative research. In order to move away from what they called the “distorting subjectivities” of the researcher, Glaser and Strauss (1967) introduced a systematic approach to interpreting qualitative data. This approach emphasised the inductive nature of data collection and analysis, which stresses that the researcher has no preconceived ideas to either prove or disprove (Morse, 2001), thus allowing the

emergence of areas of importance within participants stories. In order to achieve this emergence of theories from the data, Glaser and Strauss (1967) considered that this could only be achieved by an analytical technique that allowed for a constant comparison between participant data and later between the codes and categories that had emerged from these initial data comparisons. Only by constantly comparing the data, codes and categories could theories be truly considered to be grounded in the participants' experiences (Mills, Bonner, & Francis, 2006). Clarke (2005) also argues that traditional grounded theorising is not only grounded by the data, but also by "*the analyst's commitment to representing all understandings, all knowledges and actions*" (Clarke, 2005, p.4).

Reflecting on the early works of Glaser and Strauss, Charmaz (2000) and Locke (2001) amongst others have noted the positivist leanings of many of the aspects of grounded theory. The lack of reflexivity and the need for the researcher to remain invisible and the search for purity in grounded theory are just two of the positivist "recalcitrancies" that Clarke (2005) also focuses on as evident in early grounded theorising. Manning and Cullum-Swan (1994) have suggested that in 1960s America this leaning towards positivism was common. However, even though, in more recent years, many researchers and theorists using grounded theory have moved away from the emphasis on researcher invisibility and other such positivist constructs, there are still some who view any diversion from the original process of data collection and analysis and the assumptions underlying this, as a move away from "true" grounded theory (Glaser, 1992).

It would seem then, that a split has developed in the grounded theory arena. Differences began to occur when the two founding fathers of the grounded theory method went their separate ways. Glaser, on the one hand, held firm in his position that the assumptions underlying the process of data collection and analysis in the original or traditional approach were essential to allowing a true grounded theory to emerge from the data (Glaser, 1978; 1992). In particular, Glaser's (1978) stance on the position of the researcher in the research is that he is a neutral, invisible observer of the data. Whilst Strauss, on the other hand, "locates agency for theory development in human researchers" (Locke, 1996, p.240) and sees the researcher as being vital to interpreting and opening up the data to further discovery (Strauss & Corbin, 1990). This led to Glaser (1992) accusing Strauss of abandoning their traditional grounded theory and

forcing the data by introducing a variety of data analysis procedures, rather than letting the theory emerge from the data. It appears that where one stands on this debate is dependent in part on your epistemological stand point and what you believe about the nature of truth. Although Strauss never declared himself to be a social constructionist and many aspects of his work still held true to some positivist tendencies, Charmaz, (1995a; 2000) and Locke, (2001), have both found that by giving voice to those they study, Strauss, together with Corbin, have moved toward a post-positivist position. In fact, Strauss and Corbin (1994) clearly stated their position on truth and reality to be “that truth is enacted” and declared their version of grounded theory to be an evolved grounded theory.

So far I have laid out the beginnings of grounded theory, through to the emergence of differences in opinion and method which appear to be underpinned by a difference in epistemological stand points, from the positivist to the relativist (post-positivist). However, the story so far has been involved in taking us away from the positivist rather than towards a postmodernist grounded theory. It would seem that there is still some way to go to “push grounded theory past the post modern turn” (Clarke, 2005). Charmaz (2000) was the first grounded theorist to actively position herself and her work within a constructivist epistemology and has been hugely influential in her efforts to once again evolve grounded theory further from its traditional roots. Not only did Charmaz (1995a; b; 2000) advocate for the notion that realities that emerge from the data are due to the “*interactive process and its temporal, cultural and structural contexts*” (Charmaz, 2000, p.524), but that these realities should be conferred and written in such a way that does not transcend the participants experience. Both of these are clear indicators of the nature of reality and its construction between the researcher and the researched, as well as the need for the researcher to not only take account of but to give voice to the multiple perspectives, reflexivities and voices within the data, rather than taking the position of the authority and allowing the “expert” voice to be dominant (Clarke, 2005).

Although the work of Charmaz has evolved grounded theory even further from its traditional routes, Adele Clarke (2005) proposes that it can be pushed even further to include all that Charmaz (2000) amongst others (Locke, 2001) has suggested and more. Clarke (2005) has based her evolution of grounded theory firmly in the theory and ontology of symbolic interactionism, “moving grounded theorising from social

process/action to social ecology/situation” (p.37) and thus grounding the analysis in the situation that is being researched. Clarke (2005) admits that there are some aspects of symbolic interactionism that have been criticised by the likes of Denzin, (1996a) and others for being positivist in nature (in particular, the reliance on the assumption of a shared reality). She proposes that the areas of symbolic interactionism that she draws on are already implicitly post modern in nature and that those not already will be updated and pushed “around the post modern turn” (Clarke, 2005).

### **3.3 Situational Analysis**

Clarke (2005) explains her notion of situational analysis as a move away from the traditional grounded theory with its positivist roots and assumptions towards;

*“creating representations that basically assume differences and multiplicities and seek to explicitly map and represent them.”* (Clarke, 2005, p.19)

In order to do this and to make her notion of grounded theory truly based in post modern epistemology, she argued that the need for reflexivity is paramount, as is an understanding that all knowledges, as well as being co-constructed by the researcher and the researched, are also situated. That is, if the situation of inquiry was different then the truths being co-constructed would also be different. Clarke (2005) talks at length about the roots of situational analysis, one of which has already been touched upon, social interactionism. Social interactionism, in particular the work of Strauss (1978) on social worlds and arenas forms part of the basis for Clarke’s (2005) situational analysis. Social world’s theory assumes multiple actors who are grouped by means of shared commitments, sharing certain resources to achieve their goals and creating shared ideologies as means of achieving these goals (Strauss, 1978). According to Mead (1938, p.518), social worlds can be viewed as *“universes of discourse”* and are the main way people organise social life. Society therefore can be considered to consist of multiple levels of social worlds and arenas with each person belonging to more than one, some of which are formalised (such as occupations) whilst others are more taken for granted and could be considered as *“going concerns”* (Hughes, 1971).

The second key aspect of situational analysis according to Clarke (2005) sees the work of Strauss and the social worlds/arenas meeting with the work of Foucault. She explains that whilst Foucault was concerned with power and the historical, cultural and

temporal elements that constitute subjectivities, Strauss was concerned with issues of action and negotiation between different social worlds and arenas to arrive at knowledges (Clarke, 2005). It appears to be this emphasis on reality or truth being the outcome of an interaction or negotiation that makes Clarke (2005) consider positioning the work of Foucault alongside that of Strauss. However, Clarke (2005) is at pains to state that these apparent similarities are by no means meant to equate to equivalence in their theories, but more as sites of “articulation” that each have in common but with different emphases. The third aspect that Clarke (2005) sees as crucial to the work of situational analysis is the existence of non human elements and the need to take them explicitly into account. Objects, which can be classified into physical objects (chairs, tables, etc.), social objects (students, friends, etc.) or abstract objects (moral principles) are considered by the meaning that a certain person or social world has for it (Blumer, 1969). This idea of non human elements being constructed by and in turn constructing and organising the worlds/arenas that they belong to and beyond, is something that has not been made explicit before, but is something that Clarke (2005) places emphasis on in her notion of situational analyses.

The final root or underpinning assumption of situational analysis lies in the extension of Strauss and Corbin’s (1990) work on conditional matrices to the situational maps proposed by Clarke (2005). Strauss (1993) saw conditional matrices as a means of capturing the “conditions under which the action of concern occurs”. He then used these matrices to distinguish among causal, intervening and contextual conditions. Whilst Clarke (2005) agrees with the notion of such matrices and the idea that some elements are more important than others, she expresses concern about the fact that these ranks of importance are made by the researcher and moreover states that the situational maps that she proposes look at the situation as a whole and is thus able to examine the distinctions from the perspectives of different actors. Rather than looking at the elements as casual or contextual, she prefers to focus on the relationships between elements and understands them as co-constitutive (Clarke, 2005). So, instead of a matrix that positions the individual at the centre with different layers of levels (group, family, organisational, through to global) spiralling out, Clarke’s (2005) situational maps place the situation of inquiry at the centre with all the other element (human, non human, discursive, organisation, etc.) radiating out from this point, indicating no causation, just relations.

From the outline of Clarke's (2005) situational analysis and the assumptions and roots underpinning it, it can be clearly seen how she is attempting to place this evolution of grounded theory further along the methodological spiral (Annells, 1996), just as Charmaz has done before her. But this time, placing the situation of inquiry at the heart of the research rather than just the individual social processes. It is this emphasis on the situation and the acknowledgement that key elements can be co-constitutive in creating a reality, knowledge or truth, that seemed to fit with the research that I wanted to carry out.

### **3.3a *Situational Maps***

*“Strategies for articulating the elements in the situation and examining relations among them” (Clarke, 2005, p.86)*

This literally means describing all the human and non human elements that are involved with the situation being researched. Once all of these elements have been identified in the data, they are then used to think about the relations that might exist between them. This is achieved by taking each element in turn and considering how it might relate to the other elements that have been identified. As with traditional grounded theory, this kind of map should be completed after each encounter with new data. In the case of my research, that involves the noting down of initial thoughts or memos following each interview, then the careful transcription of the interview, followed by an initial coding or identification of the elements represented within the data, before mapping them in terms of their relationships. This constant comparison is essential (as in traditional grounded theory) in order to begin to notice the emergence of theories relating to the situation of inquiry, whilst at the same time also noting any elements that did not emerge that I might have expected. This allows for the next interview to take account of both the emerging theories as well as those that were absent. This comparison processes occurs between each interview. Not just comparing the first with the second, the second with the third and so on, but constantly comparing all the elements and relations in all the interviews with each other. With each interview, the situational map will evolve and several versions of the map might come into existence with key elements being introduced with new interview data and new relationships identified. Clarke (2005) proposes the use of messy maps to begin this process before moving onto ordered maps that outline the key categories that have emerged from these messy maps.

### **3.3b Social Worlds/Arenas Maps**

*“Cartographies of collective commitments, relations and sites of action”*  
(Clarke, 2005, p.86)

This stage moves the analysis towards seeking to work out and specify the key social worlds in existence within the situation of inquiry. Once these have been identified it is important to then at least make notes on the key discourse of that world that have arisen through the course of analysis and mapping. When thinking about the social worlds and arenas Clarke (2005) also suggests that it could be important to not only think about and note the relative power and size of each world, but to consider finding a way of making this graphic-maybe by changing the size of certain worlds relative to others or the power and relative position that they take within the situation of inquiry, also it is necessary to make clear how certain worlds and arenas might overlap with others within the situation. The next stage of social worlds/arenas mapping concentrates on describing each world and arena in detail, which enables a deepening understanding of the map and helps in the process of making the representation of the map fit better with the interpretation of the data. Once complete, the maps and memos of the worlds and arenas in the situation help to present an overall picture of the structure of action within the situation.

### **3.3c Positional Maps**

*“Simplification strategies for plotting positions articulated and not articulated in discourses”* (Clarke, 2005, p.86)

The final element of situational analysis involves mapping the key positions that have been taken in the data on “major discursive issues” within the situation of inquiry (Clarke, 2005). The goal is to represent the data by making known the positions that have been articulated or not articulated without placing them as normal or deviant or belonging to particular groups of people. Clarke (2005) sees this latter point as crucial to positional maps within situational analysis. She asserts that in line with post modern thinking “positions are not correlated or associated with persons, groups or institutions” but are seen as positions in discourse that are either taken or not taken. However, one

key question remains in my mind-if these positions are not related to the situation of inquiry in terms of the social worlds, arenas or elements that co-constitute them, then why do they? Clarke (2005) answers this question by suggesting that it allows the researcher a space to think of the heterogeneities which are often difficult to see, which in turn enables the researcher to ultimately see more clearly the positions that are situated in these areas. So, when looking back at situational and social worlds/arenas maps it is possible to notice situated positions that had been missed or only half understood in the initial mapping.

### **3.4 Issues of Rigour**

Having outlined the three main means of achieving a situational analysis it is essential to consider how these might stand up to scrutiny. There is no point carry out research that cannot “hold water”, but with qualitative research the notions of reliability and validity that are used to scrutinise quantitative research methodologies and their findings, do not appear to have the same relevance. Qualitative research is not interested in being able to generalise its findings or in showing that it has the true answer to a certain question or set of questions, but that does not mean that it should not be interested in showing that it has been carried out in a rigorous manner and thus rendering the research and its outcomes as credible. However, there is considerable debate in the qualitative world over what constitutes rigour and how best this can be achieved. Since qualitative methods of research have become more and more popular over recent years, the concerns that have been levelled at this research paradigm are mainly associated with claims of bias, inter-rater reliability when coding data, sampling and sample size and concerns about the generation of new theories (Barbour, 2001).

Despite the debate there appear to be some consistent suggestions for maintaining standards and rigour across qualitative research. These will each be outlined and discussed in turn to allow for a clear understanding of the principles of rigour as well as how they are addressed within this research.

#### ***3.4a Sample Size***

In grounded theory, the notion of sample size is addressed by what Glaser and Straus (1967) call theoretical saturation. This means that;

*“a) no new or relevant data seem to emerge regarding a category  
b) the category is well developed in terms of it’s properties and dimensions demonstrating variation, and  
c) the relationships among categories are well established and validated.”*  
(Strauss & Corbin, 1998, p.212)

Clarke (2005) states that this rule of continuing to expand the sample size until theoretical saturation occurs, is also key to situational analysis. The scope of the research question can also dictate the sample size required to reach theoretical saturation (Morse, 2000). It is for this reason that Strauss and Corbin (1998) recommend that the focus of the research question is narrowed to reduce the number of interviews required. The sample should also be able to reflect a clear picture of all the patterns, concepts and properties relating to the research question (Auerbach & Silverstein, 2003). In this case it means that representatives from as many as possible of the staffing groups from within the multi disciplinary team are interviewed to allow for the emergence of concepts that give a clear picture of the team as a whole. Another aspect that might also affect the sample size required relates to the ability, experience or knowledge of the researcher. Morse (2000) suggested that researchers with more knowledge of a given area might be able to use their insight to formulate questions that are able to get to the heart of the phenomena being researched more efficiently than someone who has no knowledge of a certain field. Although this insight must be used with caution and made explicit so that the researcher can limit the chances of influencing the interpretation of the data or even missing valuable insights made by participants altogether (Strauss & Corbin, 1998).

In the case of this research, I clearly have a certain amount of insight into the organisation of the unit in question as well as a knowledge of patient engagement from the perspective of two of the different disciplines (Psychology and Nursing). Whilst this has enabled me to locate participants who might hold key knowledge and information relevant to the research question as well as understanding the power dynamic at play, I have had to be careful to use my experiences only as a guide to knowing who to interview and possible questions to ask (and not ask, that might be irrelevant) whilst acknowledging that there is no point asking the questions if I do not allow myself to listen to and explore each participant’s insights. This was also crucial when assessing when I had reached saturation point. Whilst it is important to acknowledge the subjectivity of this decision and that one can never be certain that

another interview would not show something new, the above process supported my decision to end with the seventh interview. Going through the process of constant comparison after each interview and looking not only for similarities but also differences between participants allowed me to see when codes and categories were becoming well developed as well as when questions still needed to be asked. The point of saturation, for me, was also a point of clarity. By this I mean that through the constant comparison and theoretical sampling, all the ambiguous aspects and questions that I required answers to, were, on the whole, satisfied. (The advantages and disadvantages to being an insider researcher are discussed more fully later).

### ***3.4b Theoretical Sampling***

Theoretical sampling in grounded theory goes hand in hand with sample size and in particular knowing who to interview. If the sample size is dictated by theoretical saturation then it seems clear that if you talk to people who are the most relevant to the research question then it is likely that you will reach saturation sooner than if you talk to people on the periphery. This also enables the researcher to obtain the best data possible (Glaser & Strauss, 1967). In line with this and bearing in mind that grounded theory and situational analysis expect that emerging themes should be followed, it makes sense that the sample is not predetermined. This allows for participants to be located who might hold the richest data in light of emerging themes and thus allow for saturation to be reached sooner (Glaser & Strauss, 1967). Knowing the unit and the staff who work there well has enabled me to look at the emerging theories from each interview and locate the most appropriate participants to follow up and provide the richest data. Whilst knowing the unit could be seen as advantageous in this respect, it also created a whole host of difficulties which are discussed at greater length in section 3.5.

### ***3.4c Validity***

As I have already mentioned, validity in qualitative research is a very different phenomena to that of quantitative validity. Many researchers have looked at the issue of validity and given descriptions of this construct, however, I feel that Maxwell (1992) gives a concise and well defined overview. Maxwell (1992) proposed the following types of validity; descriptive, interpretive, theoretical and generalisability.

### *3.4ci Descriptive Validity*

This refers to how accurate the data is and is comparable to the concept of credibility used by Glaser and Strauss (1967). For descriptive validity to exist then the data must be an accurate reflection of what the participant actually said. So, the transcription of the data must be verbatim but also must include all features of the participant's speech, such as emphasis and pitch (Maxwell, 1992). Glaser and Strauss went so far as to say that the analysis and emergent theories were irrelevant if an accurate account of the data was not available.

### *3.4cii Interpretive Validity*

Maxwell (1992) describes this as relating to how well the researcher captures the meaning of what a participant says or does during an interview. It is crucial that the meaning comes from the perspective of the participant and not from that of the researcher. This means that any interpretation must be supported and shown through the data.

### *3.4ciii Theoretical Validity*

Maxwell (1992) as well as Auerbach and Silverstein (2003) have stated that if the researcher has not provided an accurate explanation of the phenomena being researched and shown how they have arrived at a theory that fits the data, then interpretive validity has not been achieved. It is therefore not enough for the researcher to highlight a pattern and propose a theory as to why this pattern exists, data must be produced that supports this theory. This concept of interpretive validity is very much in line with Glaser and Strauss's (1967) idea that theory is data driven. The above three types of validity can all be assessed and ensured by using both participant validation and multiple coding, whereby the researcher allows other researchers to access the data and independently code it.

Although these types of validation can help to ensure that the researcher is using the data to ground the emerging theories and can provoke discussion over areas of

disagreement, some researchers disagree with this process. Morse (1994) suggest that it is impossible for a researcher who was not present during the interviews to code transcript data as they do not have access to all the non verbal information that the researcher has, such as facial expression, interruptions, etc. It appears that there are valid points from both sides, so for the purpose of this research, participant validation and multiple coding have been used, but with an awareness that points of discussion or disagreement might arise which I might have to make a judgement call on, supported by my knowledge of the process of the interaction in the room. This can be achieved successfully, I feel, by noting any concepts that caused debate and making explicit the reasons for continuing that line of enquiry.

### *3.4civ Reliability*

As I have previously mentioned, certain issues of rigour are more traditionally associated with and directly applicable to quantitative methodologies. One such issue is that of reliability. In quantitative terms this refers to how repeatable the findings are and whether running the same experiment would achieve the same results. In a qualitative study such as this, reliability would be largely associated with how dependable and theoretically valid the findings are. In other words, that different researchers reach the same interpretations, repeated examinations of the data produce the same observations and that multiple researchers would produce similar interpretations of the data. All of these have been discussed under the different headings above. With regards to this research, I ensured that, as I outlined in the previous section on theoretical validity, all the coding and categorising took place with the support of two independent coders as well as being taken back to individual participants to check that I had interpreted their words accurately into the sets of codes and categories.

### *3.4cv Generalisability*

The notion of generalisability in qualitative research is troublesome and would appear to go against the epistemological underpinnings of the paradigm, however, Maxwell (1992) has suggested that although not looking for universal truths, qualitative research can have two levels of generalisability. Although Maxwell (1992) uses the term generalisability, I feel that this holds too many quantitative connotations and prefer to

use the term that Walsh (2003) calls transferability. Auerbach and Silverstein (2003) have called these two levels the external level and the internal level. The internal or situation specific level transferability refers to how the concepts and theories could be applicable in other similar situations. Whilst external or the abstract level of transferability relates to how these concepts and patterns could be more widely applied. In this case, the very specific in patient setting and type of clients being cared for would mean that internal transferability could find theories derived from the study being applied across similar inpatient psychiatric settings. However, the holistic process of engaging with patients may be more generally applicable to other areas of the health service where engagement is crucial.

#### ***3.4d Transparency***

One other area of importance in terms of rigour is what is called transparency. Auerbach and Silverstein (2003) propose that it is essential for the reader of the research to understand the process of the research and how the researcher arrived at certain interpretations. They also state that everything about the research should be explicit, from sampling, to design and interview protocol, coding procedures and researcher reflexivity. This allows for the reader to make the best sense of the findings that they possibly can, even if they do not agree with the interpretations, they can see how the researcher arrived at them. Key to this, I feel is reflexivity and my own position (although already briefly outlined) is given priority in the next section, as well as an overview of the advantages and disadvantages of being a researcher in a setting where you are known.

### **3.5 The Known Researcher**

What I bring to this research, from the very beginning of the process (considering an area to research) through to the end of the write up of the study as a whole, is all influenced by who I am and the experiences I have had. It is impossible to ignore or bracket off the knowledge and experience I bring to this situation and it would also seem counter intuitive to do so. As a reflexive researcher I acknowledge that what I bring to the research will have an impact on both how I go about conducting the research as well as analysing the data. Having arrived at the point of believing that all knowledge is co-constructed, I have to be able to have some way of knowing what I

bring to that process and how I can use my knowledge and experience to guide the research rather than obstruct. Whilst this awareness and reflexivity is paramount in most qualitative research (I exclude from this the traditional Glaserian grounded theory that states that the researcher should be a blank slate), being both a researcher and colleague to those that I am interviewing makes it all the more important. Strauss and Corbin (1998) were real proponents of the idea that no researcher is able to come to a research project as a blank slate and as such our prior knowledge has an impact on how we conduct the interview and the data that we obtain. For Strauss and Corbin (1998) the relationship between researcher and researched was key to the data that could be obtained and they recognised that the researcher is reacting to the participant and the information they impart to create some kind of reciprocal shaping.

In my case, I have worked on the unit in question for over four years and in that time I have experienced the setting from two very different perspectives-that of healthcare assistant, working with nursing staff and management and that of Trainee Counselling Psychologist, working with the psychology department. This experience has given me a unique insight into the workings of the unit from very different angles and has provided me with a substantial amount of informal “data” to start the process of arriving at a research question and then to building an interview schedule and guiding me in the direction of suitable participants. However, there are also considerable challenges to both the research process and maintaining my own role within the team as a worker and colleague. Most of the research into how others have managed the conflicts of maintaining a dual role has come from the areas of action research and ethnography.

On the one hand, being fully immersed in the context that is to be researched, gives the researcher an insight into what research is needed, what the areas of concern or need for development is and it allows the researcher to tailor the data according to a knowledge of the situation being studied and ensures that all questions asked during interview are both relevant and contextually grounded (Kirby, 2007). However, on the other hand, it can lead to the researcher following their own lines of inquiry rather than being fully open to the data that is emerging from the participant’s. At its extreme, this can lead to valuable insights from participants being ignored and thus are not open to interpretation by the researcher, so valuable information is effectively lost (Strauss & Corbin, 1998). Being a researcher who is fully immersed in the context of the research is said to adopt an emic perspective which has also been referred to as “going native”. This is often

seen in a negative light and has connotations of the researcher only being able to take a blinkered view in comparison to an etic researcher who is an informed, but objective outsider (McEvoy, 2001).

Four main criticisms are put forward to account for this negative view of the insider researcher; firstly, the tendency to take for granted common experiences which would make it difficult for the researcher to question aspects of the social world that seem obvious (Schutz, 1944). Secondly, the idea that an insider lacks the distance required to maintain a balanced perspective of that social world (Stephenson & Greer, 1981). Next, some consider that as the researcher is subject to the constraints of group membership, they are discouraged from asking questions about certain social mores (McEvoy, 2001). Finally, it is suggested that some insiders might be reluctant to talk to a member of their social group about sensitive topics (Horowitz, 1986). Against these criticisms are those who argue that it is the emic researchers' unique position that enables them to accurately interpret participant's data (Hinds, Chaves & Cypess 1992). Although there are two polarised views presented, for me it does not mean that one is right and the other wrong, more that they highlight the advantages and disadvantages of researching using the people you work with.

One last point that I would like to consider is that put forward by Narayan (1993) who states that no matter who we research,

*“there will inevitably be facets of self that join up with the people we study and other facets that emphasise our difference”*

For me, it is the awareness of all of these things that is crucial. That I might identify with some of the insights presented by participants, that I might need to remind myself to take a step back and truly listen to what the interviewee is telling me and follow their thought process and not simply my own. But also, an awareness that I hold a privileged position in being able to use my own experience to guide me to explore the experiences of others.

### **3.6 Ethical and Political Considerations**

As well as the advantages and disadvantages of being an insider researcher, there are also a number of both ethical and political issues to consider. Conducting research in ones own organisation, using colleagues as participants poses a number of ethical and

political challenges to the researcher. After all, you are asking your colleagues to not only consent to take part in the research, but to also divulge information, that whilst it is hoped will be of benefit to facilitate positive change within the organisation, is often also of a highly politically sensitive nature. Issues of consent and confidentiality can also become blurred as researcher and participant already have a relationship within the situation of inquiry. Although all participants were given an information sheet and consent form outlining what would be expected of them, what would happen to the information they gave and who would have access to it, whether the consent they gave was truly informed is something that I have struggled with.

It is possible that although participants readily agreed to take part in the interviewing process, it could be for many reasons. One such reason being that they might have felt they could not decline for fear of appearing discourteous or damaging the working relationship we already had (McEvoy, 2001). This issue is often highlighted when there is a power differential between the participant and researcher (McEvoy, 2001). In my case, as I hold no management or supervisory control or power over any of the participants, this concern was minimised, though the power I had as the researcher to interpret the information given to me, was not lost on me or participants. In many cases, whilst in the process of explaining the nature of the research, how the data would be used and asking participants if they had any concerns, I often obtained the response that they trusted me to use the information appropriately.

This placed a huge burden on me as a researcher, knowing how to represent the data in a way that was both sensitive and yet not shying away from the political content and implications of what the participants said. Another could be that talking to me informally about such matters was already common place and so the full impact of asking them talk about such issues in the line of research could have been lost, McEvoy (2001) also makes note of this phenomena and discusses the ethical dilemmas this can place on the researcher. If a colleague talks about something like levels of care that fall below the accepted levels of patient care then the researcher needs to find a way of balancing the responsibility to patients and the responsibility to maintain confidentiality and trust with the colleague (McEvoy, 2001).

The boundary between overt and covert research is also one that is unclear when working within the organisation that you are researching. I cannot help but be privy to

information that an outsider would not necessarily have access to, through attending meetings and just generally being immersed in the culture of the context. There have been times that I have had to carefully consider how I will use information that I gain outside of the formal research boundary, so, outside the participant interviews. Managing these boundary issues has been one of the key tasks of this research and has not always been straight forward. However, through making it my priority to inform participants of the nature of the research and the way in which it will be presented, as well as making clear how I will be maintaining anonymity and confidentiality in every way possible, I hope that the issues of consent are at least minimised.

Within the consent process, participants are also made aware that I have an ethical duty to them as well as to the organisation as a whole and that whilst I will respect their rights to confidentiality, should issues arise that I feel compromise my ethical responsibilities to patients or other members of staff, then it will be my duty to first discuss this with them before disclosing to the appropriate authority. Within my duties as a researcher I also have a responsibility to ensure that no harm comes to any participant as a result of taking part in the research. This could well be easier said than done as the very nature of qualitative research involves the participant openly talking about aspects of their work, life and relationships that might open up for the participant areas of previously unacknowledged or unprocessed difficulties. Although such risks of harm in this sense are minimal in this research, it must be acknowledged that through the very process of asking questions, I might open up areas of consciousness that did not exist previously and might leave the participant with a sense of not knowing how to deal with that (Duncombe & Jessop, 2002).

All of these ethical considerations have been taken into account in the preparation for this research and have been managed by offering clear and concise information on the nature of the research, the participant's rights to say no at any time or withdraw participation without incurring any penalty whatsoever, as well as outlining how confidentiality and anonymity will be maintained-by removing all identifying information from the transcript, keeping all recordings, transcripts and data securely in a locked cabinet or on a password protected computer file. And, by offering the participants access to debriefing following the interview and a list of useful resources, the chances of causing harm to the participant in light of opening up and not being able to process certain issues, is minimised (Appendix 2 and 3 for information and consent

forms). All the procedures outlined have been subject to the rigorous ethical checks put in place by the NHS COREC (the national research ethics committees for NHS) system and have been appraised by a committee to ensure their ethical soundness.

One final politically contentious aspect of conducting insider research with colleagues is the potential impact that publication or presentation of the research findings might have. With so many different audiences approaching the publication and presentation from different perspectives it is almost impossible to produce a piece of politically sensitive research that will be well received by everyone (Becker, 1967). Although member checking and using an independent proof reader to check that the research has been presented ethically (Johnson, 1982), it is difficult to judge the reactions that colleagues might have towards their portrayal in a politically sensitive piece of work. When it has been difficult to conceal the identities of the participants from other knowledgeable insiders, the feelings of vulnerability might be enhanced (Ellis, 1995). Every care has been taken to protect participant's identities, but, this may not be fool proof as insiders will frequently guess at who took part and who said what. This makes the need for finding the balance between presenting politically sensitive information and protecting participants even more important,

### **3.7 Research Design**

It would seem to me that it is only now, having covered the philosophy, analytic paradigm and all the questions of rigour and ethics, that it is appropriate to lay out the design of the research. The research has taken place at a national specialist low secure unit for patients with a mild to moderate learning disability, mental health problems, challenging behaviours and some forensic histories. This unit is within a large NHS mental health trust in London and is located in a stand alone building that is not physically attached to other wards within the hospital complex. The staff who work there comprise a mixture of professional as well as ethnic backgrounds. These staff make up what is called the multi disciplinary team (MDT) which consists of Nurses (qualified and unqualified), Psychologists, Occupational Therapists, Psychiatrists, Nurse and Unit Managers, Social Workers and Art Therapists. There are also administrative staff and domestic staff who work on the Unit but are not considered to be part of the MDT as they are not clinicians, working directly with patient care.

### **3.7a Participants**

It is from this diverse mix of people and professions that I have drawn my sample of participants. In order to obtain a fair representation of the MDT, I selected my participants to reflect the distribution of different professions. So, the Nursing group is by far the largest profession and to reflect this, I decided that half of the sample should be from this discipline. Each other discipline gets one representative, other than Art Therapy and Social Work, where there is only one team member representing each profession. In order to maintain anonymity I decided that it would be far too easy to identify them and so did not include them in my sample. This left me with a need to source one Psychologist, one member of Unit Management, one Occupational Therapist and one Consultant Psychiatrist, with the remaining participants to be sourced from the Nursing team (three in total) in order to maintain a sample that was representative of the make up of the unit as a whole. Although these participants were not pre-selected, each was chosen as the interview process progressed as they were considered to be the best source of information to further explore the emerging concepts and theories (in line with theoretical sampling).

### **3.7b Sources of Data**

The main source of data comes from semi structured one to one in-depth interviews with participants. The questions and concepts for the interviews came from my own experience and knowledge of the Unit as well as the two different perspectives I had working in different roles on the same ward (see appendix for list of questions and prompts for interview). These questions allowed a basic outline but also permitted me to be flexible and respond to what each participant was saying during the interview process, as well as giving the space for the interview schedule to evolve and further explore emerging concepts and theories. My own observations of the structure (physical design of the building) and functioning of the unit are also incorporated into the analysis.

### *3.7bi Interviews*

Each participant was invited to take part in a one to one interview with the researcher to discuss their thoughts on working on the unit, both with patients and staff. Each interview took place at a time that was convenient to the participant and in a place that was convenient to them. In some instances the interviews were interrupted several times by the demands of the ward, but each time the participant was given the choice to continue or postpone the interview. Every time, the participant chose to continue. Interviews ranged in length from 48 minutes to 90 minutes and all were recorded using a digital voice recorder before being transcribed verbatim.

### *3.7bii Field Notes and Observations*

These were made throughout the process of research, other than during interviews when it felt most appropriate to fully engage with the participant by listening and developing a relationship rather than note taking. This does not mean that mental notes were not made and then transferred to the filed notes as soon as the interview finished. Staff meetings were also a valuable place to take note of general themes arising as were conversations that took place on a more informal level. These observations all assisted in being able to contextualise the research.

### *3.7c Constant Comparison*

In line with grounded theory and situational analysis techniques, each set of data went through a process of constant comparison which has been outlined in the above sections, to enable as full an exploration as possible of emerging concepts and theories and to reach theoretical saturation. This means that data analysis and methodology are almost inseparable when using a grounded theory/situational analysis framework. However, they can be distinguished by the level at which the categorisation and coding occurs and the emergence of a set of concepts which has reached saturation point. This is when the final analysis and emergent theories can be represented and mapped from the data.

## **4.0 Results and Analysis**

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The purpose of this section is to look at how people from different professional backgrounds construct patient engagement and the factors they think impact on their ability to engage patients on the ward. This will be achieved by identifying the social worlds that are involved within the social arena of the inpatient unit and how they interact to meet the goal of engaging patients.

The results are therefore split into sections. Section 4.1 is an opening section that establishes the importance of patient engagement to the participants and details the process of memo and coding. The remaining three sections will present both the overall findings, to give a clear and easily comprehensible overview, as well as showing the detailed process of analysis from the earliest stages of memo-ing and coding through to the final coding and presentation of core categories, in order to show that emergent theories are grounded within the interview data.

Section 4.2 explores how participants construct the process of patient engagement and identifies the categories of relational elements, the evolving process and levels of engagement and discusses the relationships between them.

Section 4.3 identifies the social worlds that exist within the arena of the inpatient unit and outlines the areas of negotiation and communication between the worlds as well as presenting the perceived power differences between each social world.

Section 4.4 details the different categories that participants felt impacted upon their ability to engage patients. These will be discussed in detail before presenting a model of how they form part of a system that either enhances or inhibits staff ability to engage patients.

Throughout the process, quotes are given. For ease of understanding some quotes had to be shortened. Where this is the case, three full stops (...) will be used to signify this. These are only a selection relating to each code or category, for further examples I would direct you to the appendices (appendix 4).

## **4.1 What is Patient Engagement?**

This section serves to introduce the main thoughts of participants on the importance of engagement before the core categories relating to how participants construct the process of engagement are discussed in detail in section 4.2. One thing that quickly became clear during the process of the interviews was that regardless of discipline, all participants agreed not only on the major components that make up patient engagement, but also on the centrality and importance of it to working with patients to achieve good outcomes. I had not expected such a unanimous agreement and perhaps the most striking interpretation of the importance of engagement can be seen below;

Peter: Well it's one of those assumptions I suppose, I haven't really thought about it before, yes of course it's important, it's as important as being awake; you know, "can you do anything if you're asleep?", well, "no, not much..." Yes it's a fundamental thing.

Although it appears that everyone feels that engaging patients is a crucial part of working with patients and plays a vital role in why they come to work each day, it was not yet clear whether everyone was talking about the same thing when they referred to engagement.

### **4.1a A Process of Relating**

Before I had started to interview participants I had assumed that each discipline would have their own way of understanding patient engagement and that this would be associated with the different types of activities that each discipline carries out with patients. However, instead of talking about patient engagement as specific and concrete things or activities that one does with or to patients, participants talked of deeper level processes that often enabled the end result of the client being able to take part in activities and generally participate more, become better able to interact with others and utilise more effective and socially appropriate means of relating to others.

#### 4.1b Memos and Coding

These deeper level processes became apparent from the moment that I asked participants what the term patient engagement meant to them. The memos I wrote following each interview and at each stage of the coding process invariably had the word relationship in capital letters next to this aspect of the interview schedule, but also with a variety of questions, ideas and associations leading from them. An example of an early memo can be seen below and shows how I noted all my initial thoughts and ideas after each interview.

Interview 1	What is Engagement?
21.03.08	
<b>RELATIONSHIP</b>	
Understanding – empathy?	
Getting to know someone – Aware of changes in mood/triggers	
Communicating – verbal and non verbal	
Treating patients as equals but maintaining a professional boundary? How is this achieved? Is it?	
Not us vs them?	POWER?
Not just one thing – different for different people. Flexible/individual?	TRUST?
2 way process	
Long term rather than short term thinking – not about doing one thing/activity but about taking time to build a relationship that will enable growth and development?	
What about activities? How does the programme session fit with this notion of engagement?	

Fig. 4.1 Example of Memo

The memos were then used to inform subsequent interviews and to refer back to when carrying out the line by line coding. Throughout the process of interviewing and coding, memos similar to the one above were made. As the coding process progressed from line by line to more focused coding and finally to reaching core categories, the memos were used as a constant means of tracking changes and developments in the

coding process as well as identifying core categories and the relationships between these core categories and other codes.

## 4.2 The Core Categories and their Components

### 4.2a Relational Elements

When talking about patient engagement, participants placed an overwhelming importance on what I have called relational elements. This category is defined by the importance placed on the fact that engagement is a **two way process** and that staff are not “doing to”, but that both staff and patients are active in the process. By being active in the process, participants talked about understanding the patient and thus being able to offer engagement that was appropriate to a particular **individual** at a particular time. In other words, that the patient is seen as an individual rather than just as a “patient” who is the same as all “patients”. **Trust** was also considered to be an important aspect of this category. When talking about trust, it became apparent that this was again an aspect of the two way process but that initially the emphasis was on staff to prove to patients that they could be trusted rather than coming from a position of assuming that patients would trust them just because they are staff. Participants felt that this enabled a **connection** to be made with the patient that in turn enhanced the level at which patients communicated with staff and became active in the two way process.

All of these aspects of the category named relational elements are linked to one another to form the process of building a relationship. Essentially this category appears to suggest that the relationship between staff and patient lies at the centre of patient engagement and that without these relational elements, engagement would be negatively affected.

Angela: Yeah and there's no one way of working with each person. It really keeps you kind of thinking all the time about how you're gonna work with somebody and how you approach them, what's meaningful for them rather than doing things because that's the way it's always been done or that's the way that we think somebody would want to do something, it's kind of really finding out about them and understanding them, before you can actually do the real work with them.

Although the relational elements have been identified as crucial to patient engagement within this setting, they are not the only categories that have been associated with the way in which staff construct the processes involved in engagement. What the relational elements do appear to be is a platform from which other aspects of engagement can blossom.

#### **4.2b Levels of Engagement**

This category is one such factor that stems from the core category of relational elements. This category emerged as participants talked about and explored the notion of engagement. Frequently they reflected on experiences with certain patients and what they had done or seen as important at the beginning of that person's admission to the ward and how this had changed by the time that they were discharged as well as comparing patients and how engagement was different or similar. This led to participants talking about the way in which they constructed engagement as something that occurs at a number of levels. The codes that make up this category are **level of complexity**, **level of understanding** and the **level of involvement**, both at the day to day and service provision stages.

The level of complexity emerged mainly in relation to the nature of the engagement that staff were trying to achieve with patients. Often examples were given of tasks or activities being graded in complexity, but the level at which the patient communicated was also seen as an important aspect of complexity, ranging from making eye contact to talking at an in depth level about emotions or complex issues.

Angela: So it's a doinky thing but it could be the doinky could be just saying, hello or you know, maintaining eye contact or just starting off a brief form of communication. So it could be just first form of engagement but it's kind of working towards them doing an activity that works towards goals that are meaningful for them and something that they can progress in really, be it small steps towards that. So, it could be something that's very complex and demanding, it could be just sitting with me for 5 or 10 minutes and doing something or just acknowledging that I'm there.

Allied to this, participants often talked about goals and there was a sense that the ultimate aim or outcome of engagement was to enable patients to work towards goals that have individual meaning for them. What also began to emerge was that there were also different levels of understanding involved in working towards goals. It seemed that participants saw that a high level of understanding of the meaning of any given task or goal equated to a greater level of engagement. Of course, it was acknowledged that there were often many confounding variables to this, such as level of intellectual impairment or mental health difficulty, but these were not seen as something that would preclude the patient having at least some level of understanding of the meaning and personal significance of goals.

Angela: ...whether they really want to be here is obviously gonna because there's lots, you know quite a few people here that can't see why they're here. So, to go along with something and work towards some goals or undertake something is, it's all very, almost tokenistic, if you can't see why you're here and then, oh but I'll engage with this session... just keep checking back whether it makes sense to them why they're doing it because it's very easy to just get someone to do something so it looks like you're doing something nice with them and they're going along with it and actually they're just doing it because they haven't got, they're not able to say, no I don't wanna do this.

The last constituent of this category is the level of involvement, both at the day to day and service provision levels. It emerged that from the interviews that participants felt that patients within the unit were encouraged to become involved with their treatment and decisions made about their care, from the very earliest stages. This meant that even from the assessment stage and pre admission, participants felt that the contributions and wishes of the patient should be sought before decisions are made. This again reinforced the notion of those who were interviewed of engagement being a two way process between the patient and the service or staff involved in their care. Despite this, the factors of capacity to consent given different levels of intellectual impairment and mental health problems, were again seen by those who took part as negatively impacting the level at which the patient could be involved in decision making on a day to day basis as well as when discussing treatment options. Although the two codes of level of understanding and level of involvement appear similar, and are closely related

to one another, they are in fact different. Understanding was talked about by those interviewed as a process where patients made sense of the goals they were working towards and the activities they were engaged in, but involvement was more about the capacity to decide and set goals in the first place.

Tom: ...where possible, when they are able, then their engagement should be sought from the very early stages, not just on you know, what I've, we've decided that you are gonna be given family therapy for your aggression problem but it's something that needs to be discussed with them that these are the different options and kind of come to an agreement, negotiate treatment together

What became clear when participants talked about all levels of engagement was that they were dynamic and not static and that patients could move between the levels in both directions (participants talked of a move to a lower level often being associated with a decline in mental health or an increase in external stressors). What was acknowledged by participants was that engagement is a process that takes time and the initial early stages of engagement should not be diminished, overlooked or rushed. As well as this, there also seemed to be a great deal of emphasis on the benefits that could be gained by taking the time at the early levels, with participants emphasising the two way nature of moving towards a higher level of engagement. Participants felt there needed to be awareness on the part of the staff as to how best to adapt the way in which they were engaging with patients.

Jane: ...I could challenge her on difficult things but then I could also praise her for not losing her temper with me because I've challenged her. So, but I would have never been able to have done that if I hadn't spent the time and done my groundwork on her and that's just part of an every day kind of routine and talking.

It would appear that without acknowledging the levels of engagement, in particular the relational elements which are akin to rapport building, and taking the time not to push patients to reaching the higher and more complex levels of engagement, real progress could be made in terms of gentle encouragement and challenging. This in turn enables movement to be made in the direction of higher level engagement. In other words, not

“running before you can walk”. However, what appears to be crucial for the participants with respect to the levels of engagement are the relational elements. Without these, then it is almost impossible to set and work toward meaningful and appropriately complex or simple goals. Those who were interviewed explained how the relationship is key to the success of establishing what has meaning for an individual, if the two way process is not encouraged then meaning cannot be identified.

#### **4.2c Evolving Process**

It has already been noted that the level at which a client engages can and should change over time. Although mental state, intellectual functioning and taking time at the early levels of engagement have all been highlighted by participants as part of the process of moving between levels of engagement, they are not all participants talked about. The previous category stressed the view of those who were interviewed that just doing something is not enough to be considered engaging. This category highlights the importance of engagement being an evolving process that occurs via a process of promoting **attention** and **new learning** and the service, as well as individual team members, offering **flexibility** and **individuality** over rigid structure and routines.

As previously discussed, engagement was not seen as something that is done to patients but something that involves an individual patient and a member of staff building a relationship which allows for goals to be set and worked towards. Once a client had reached the early levels of engagement having successfully started to build a relationship with staff, what emerged as critical to participants to remaining engaged with patients was maintaining their attention. Attention was deemed to be essential in the process of engaging. If the patient was just doing something without really attending to it, then it was talked about as having little benefit for them as they were no longer learning anything new or getting anything out of the activity. So, in order for the patient to evolve and the process of engagement to evolve, those who took part in the interview process expressed that the patient had to be getting some kind of new learning from the activity, be that at the intellectual, emotional, adaptive or skill level. However, participants stressed the importance of the relational elements in being able to get patients to attend to and learn something new.

Peter: ...well somebody who's over learned... actually it gets to a point where you don't engage with that anymore, it just becomes automatic... but a lot of activities being performed don't require any engagement, they're over learned but so I suppose what's behind the idea of engagement is new learning.... Now, how you get that, I don't know, I mean I think we have to devise lots of different ways of doing that from, you know changing the tone of your voice to visual stimuli, present something in different modes, different ways of presenting information, doing something unexpected with people. I mean anything really to try to get attention so that engagement will take place and learning will take place

It seems that being able to know when something is becoming routine for a patient is therefore critical to maintaining patient engagement as well as offering the best chance for patients to progress to a higher level of engagement and thus better treatment outcome. This once again highlights the importance of relational elements throughout engagement as without these, knowing when a patient is no longer getting something out of an activity or session would probably not occur until it was too late and some form of deterioration had occurred. What this means in real terms is that although routine and structure are important to patients, there must also be some flexibility and individuality in order to maintain new learning and limit the risk of a patient disengaging and thus not reaching the best treatment outcomes. Participants talked in particular about the need for patient centred engagement which would allow for a truly individual and flexible approach to be taken that does not just have every resident doing the same activities at the same time in order to be seen to be doing something with patients. Indeed, flexibility and evolution were also associated with patients having the choice to say no to taking part in activities. That far from always being seen as a sign of disengagement, saying no could also be seen as a real part of the engagement process. As long as this was associated with a move from mere compliance to an individual becoming more autonomous and more involved in the decision making process over whether they feel the activity or contact being offered was actually beneficial to them at that particular time. This could be summed up as reinforcing the importance of offering individualised care and engagement and activity plans.

Sandra: Yeah... the community centre each morning, being an example of that. I mean I don't know how much people get out of that now, the patients,

anymore... I mean I don't, I mean people just go for the sake of going I feel, I don't know what the... I mean some people obviously get some benefit out of it and some people but it's routine...

#### **4.2d Summary**

It would appear that all the disciplines working within the inpatient unit have a similar construct of patient engagement. And, although three core categories of patient engagement have been identified as important factors associated with how participants construct patient engagement, including the traditional notion of engagement being some kind of activity that is done with a patient, the element that was emphasised most and considered to be most important was the relational aspect.

Without staff taking time to build a relationship with patients, it emerged that it would severely negatively impact on the level of engagement that patients could reach, in terms of setting and reaching goals that had individual meaning to patients. If a relationship was not built early on in the admission process or even prior to admission, then it would not be possible to fully understand the level at which the patient could currently be involved in decision making, participate in activities or communicate with others. This in turn means that it is very difficult to have an understanding of when new learning is no longer occurring and engagement has become routine and is at risk of decreasing or being lost altogether.

So, being engaged in the entire process of treatment and decision making is seen to be crucial. Engagement starts before activities are done with patients. It should start at the moment that treatment is considered. Building a line of communication that enables a relationship to be built between patients, services and the staff involved in delivering those services appears to be crucial. I had not anticipated that participants would talk about patients having a say and a choice in what happened to them once in hospital, especially considering the nature of the patients involved, having learning disabilities and often being subject to Mental Health Act sections. However, from all perspectives, the treatment outcomes of patients were seen to be related to how well they could engage and build relationships with staff, which in turn was associated with how much input they had in the activities they took part in and the choices that were made regarding their care.

Patient engagement could therefore be summarised by the following diagram;

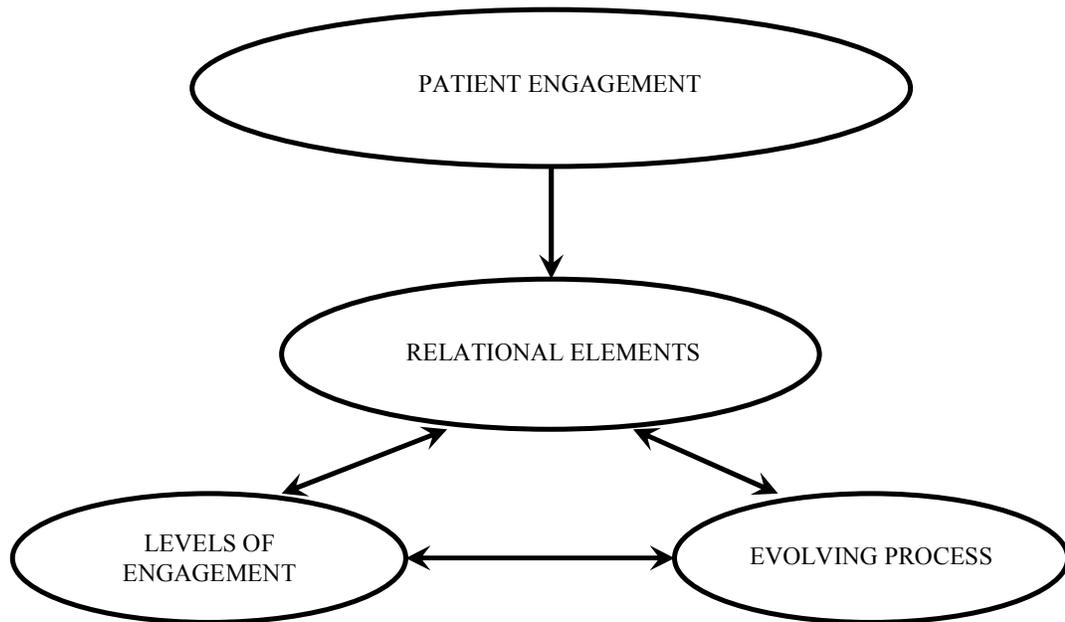


Fig. 4.2 Model of Engagement

However, what is not yet clear is how the different disciplines are working in order to meet the goals that they have described, in particular the relational element and what impacts on their ability to build these therapeutic relationships with patients. The following section seeks to address one aspect of this; how different disciplines are working within the social arena of the inpatient unit.

### 4.3 Social Worlds/Arenas Map

It would seem plausible to assume that since all staff working within the social arena of the inpatient unit, regardless of professional background have constructed patient engagement in a similar way, they would be invested in working collaboratively to achieve patient engagement as a means to reaching good treatment outcomes. The social worlds and arenas map can be used to establish how the different disciplines fit into the arena of the inpatient unit.

The process of identifying the social worlds that exist within the arena of the hospital unit is similar to that of identifying the codes and categories involved in the process of engagement. I used memos to track my thoughts after each interview and throughout

the coding process in order to establish the quantity and nature of the social worlds within the arena of the unit.

The interview data appears to clearly show the existence of several social worlds within the social arena of the inpatient unit. The social worlds are characterised by the work that they carry out and the commitments they have as well as the way in which they describe themselves and other worlds within the arena. Each social world is represented by an ellipse and is largely defined by the professional background of its members. There are two exceptions to this, the social worlds identified as “Management”, which was comprised of high ranking nurses and “MDT”, which encompassed all non nursing professionals and their individual social worlds. The first two social worlds to emerge from the data were the “Nursing” and “MDT” worlds which were the most frequently and clearly defined;

Peter:            Yeah, well yeah, I do in my head, they are separate... because there's the nurses and the MDT and I think that's right. I do think that's right and it shouldn't be, you know whatever, the formal structure is bla, bla, bla but in fact there are two groups here.

Further examination of the data revealed the existence of individual social worlds within the world of the MDT. These were identified by participants as Psychology, Occupational Therapy (OT), Psychiatry and Social Work (SW). Although it emerged that all of these had common commitments to the MDT world, they were also found to have their own commitments and differences in the nature of the work they carried out. So, although classed as part of the MDT world, they each had separate points of negotiation and communication between each other as well as the Nursing world. The participants not only identified these worlds by talking about the different groups at work within this unit, but also talked of the power differences that they perceived between each world. The following quote illustrates this;

Irene:            It's like separate, there's a separateness and there's still whatever we do, whatever we say, no matter how we try and strike a balance, there's still the upstairs and downstairs in this building. There's still the them upstairs who make the decisions and them on the ward who have to carry

out the orders and that's always been a struggle for me, that's the one thing that now still keeps me awake, is how we close that gap.

The final world to emerge from the data was the Management world. Although this world comprised staff, who by profession were Nurses, the work and commitments were distinct from those in the Nursing world and were also different to those in the MDT world. This world, although the smallest in size was considered to have the largest concentration of power, particularly regarding financial matters and issues surrounding discipline.

Mary:           They (MDT) seem more, what they say seems to make more sense to me but they're only dealing purely with the clinical stuff... whereas the managers tend to be dealing with bureaucracy.

The diagram in fig 4.3 on page 62 is a representation of the various social worlds that are in operation within the social arena of the hospital unit. The size and power of each of these worlds is illustrated here using different sized ellipses and different shades of colouring. Demographic information regarding the number of staff employed within each discipline was used to establish the size of each world, whilst my own interpretation of the interview data, from memos about the commitments and identities of each world, was used to establish the perceived power differences. It was found that the MDT and Nursing worlds actually contained a similar number of staff and so the ellipses are of equal size. Where the ellipses overlap signifies the areas of communication and negotiation between the social worlds. The two ellipses representing the main social worlds are not placed side by side as I felt that to do so would imply an equality of status which would have contradicted the evidence that emerged from the data. The MDT world is therefore placed in an elevated position adjacent to the Nursing world. The social worlds and arenas map is possibly the best way in which to graphically depict the separation and power differentials that exist on this ward.

# Social Worlds/Arenas Map

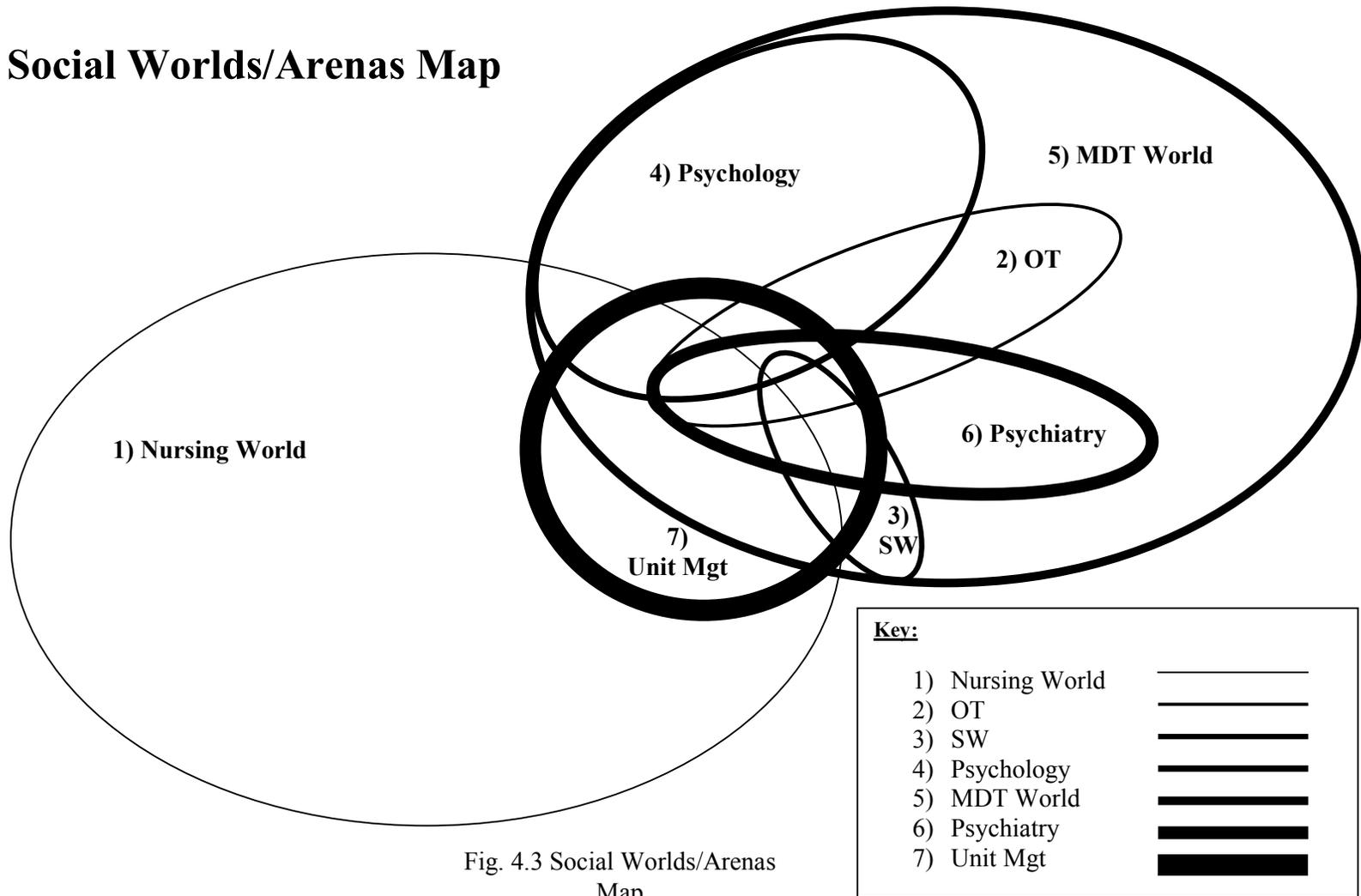


Fig. 4.3 Social Worlds/Arenas Map

It must be stressed at this point that the construction of the social worlds map is based on my interpretation of the data and the sizes of each world, although roughly representative of the number of staff in each world, are not exact. This is true for both the overlapping areas, which represent the communication between worlds and the thickness of the lines representing the power of each world. The map acts merely as a way of graphically representing my interpretations rather than there being a predetermined size or power ration laid down for constructing social worlds maps. Clarke (2005) states that these maps are a useful tool for mapping findings but that this should be done at the discretion of the researcher so that the map can best represent the data they are studying.

This social worlds map shows only a small area of communication and negotiation between each of the worlds that exist within the arena of the hospital unit. Even in the MDT world which all participants identified, there was only a small area of communication and negotiation, indicating that although a member of this world by virtue of self and other identification as well as having similar work and commitments, they are very much separate in many ways. The Nursing and MDT worlds, although equal in size, appear to be perceived as having a large power imbalance in favour of the MDT world. This social worlds map tells a story of separation between “us” and “them” or “upstairs” and “downstairs”, but what it does not show is why they are working separately and more importantly, what this has to do with patient engagement. Does the perceived power imbalance and separation have any impact or bearing on how staff engage patients?

#### **4.4 What affects patient engagement?**

To answer the question of what affects patient engagement and to establish whether the identified separation between the social worlds really does matter, participants were asked directly about what they felt impacted on their ability to engage patients. In order to identify the core categories associated with this, the same process of memoing, line by line and focused coding took place as in the section establishing how staff construct the process of engagement. However, this aspect of the analysis has proved to be far more complex than the first, with far more variation between the participants, often reflecting the different commitments and work carried out by each of three main social

worlds of the Nurses, the MDT and the Management. What became apparent throughout the analysis was that the stories the participants were telling were about what it is like to engage a patient within the context of a system (in this case, working within a multidisciplinary team within an NHS inpatient unit) as well as on a one to one basis. What also emerged from the data was that, although talking about similar themes, participants from different social worlds often spoke of them in an entirely different way and often from a very different perspective.

Despite these different perspectives, the first level of analysis showed that there was a general sense that nothing, short of the patient walking away or turning their back on staff, could stop individual participants engaging with patients at one level or another. However, there were certain factors that were discussed by participants which they felt could enhance patient engagement and others that could inhibit patient engagement. The enhancing and inhibiting factors, although prominent throughout the data at a more general level, were especially striking in relation to the answers to two key questions. These questions were “what impacts on your ability to engage patients on the ward?” and “What would the ideal unit be like?”. These two questions in particular enabled participants to reflect not only on the more negative aspects of things that get in the way or make engagement difficult, but also on the more positive things that help engagement to take place as well as things that they think would make it easier for them to engage patients. Because participants talked about both the barriers as well as the facilitators to engaging patients, the categories and codes have been set out in such a way as to reflect this. Each code and category will be discussed in terms of the inhibiting factor as well as its enhancing opposite.

#### **4.4a Separation vs Integration**

Having worked on this particular unit I have witnessed the separation that was discussed in the previous section and have experienced first hand the difficulties that this can pose. However, I feel that it is crucial to make clear that the separation discussed throughout this analysis comes directly from the data and was talked about by all participants. It was not until taking on the role of researcher and interviewing participants that I fully appreciated the level at which the separation affected staff and how pervasive it was. One other thing that I had not been prepared for was just how much of an effect participants felt that this had on their ability to engage patients.

Separation and integration were talked about by participants in connection with various aspects of patient engagement. These were chiefly split into spatial separation as well as independent vs team working.

### Spatial Separation

The manner in which the unit is laid out was talked about by all participants and the function that it serves with respect to team working and patient engagement was hotly debated. In general the feeling was that the physical design of having nursing staff and patients downstairs and everyone else upstairs has been seen at the very least to create a barrier to the flow of information and the worst as enforcing a hierarchical system whereby nurses and patients were seen to be at the bottom of the hierarchy. The idea of a territorial split between those in the nursing and MDT worlds associated with the perceived hierarchy and status of different professionals began to emerge;

Peter:           The physical design. It's just rubbish, it's just the most awful design I've ever seen in my life really, having an upstairs and downstairs and I think the physical separation doesn't help the social separation it enforces the social separation. So we just got used to it really I think, I mean that's just the way it is ... I mean I think generally the gap between the upstairs and the downstairs groups is difficult to bridge.

The above quote comes from a participant who works upstairs and appears to show that there is a general sense of a split between those who work downstairs and those who work upstairs. They hint at the sense of resentment from those downstairs and the idea that nurses are quite literally carrying out orders from "those on high", both physically (due to the building lay out) and professionally (professional status and managerial level). The sense of frustration and inequality that emanates from this separation is shown below;

Mary:           Yeah because you don't just nip upstairs do you, you go round sort of one, two, three corridors, through one, two, three locked doors, up another flight of stairs and then through a couple more doors and then you've got to find an office, so... Yeah you've got the managers upstairs, psychologists, psychiatrists, OT's, social workers; they are up there with their own lovely offices... down here, we share one office...

well up to eight staff at a time. Which makes it more tricky and you've got, you know three computers amongst six or seven staff say, all wanting to use them at the same time and I think that shows almost like a sort of disrespect, whereas the people upstairs will have their own desk with their own computer.

The above quote came from an interview with one of the nursing staff who felt very strongly that there was an inequality between those who worked upstairs and downstairs and felt that this physical separation impacted greatly on their ability to communicate with other members of the team and thus find out crucial information necessary to work with the patients and engage them fully. It also highlights another aspect of the separation between the nursing staff and the rest of the team; not having the freedom to leave the patient areas in the same way that other staff members can come and go;

Sandra: Yeah, but we're more accessible to them than they are to us. We can't leave the ward, we can't leave the floor, we can't leave the patients to tend to themselves, whereas people upstairs can leave upstairs to come downstairs.

So far, the data appears to point to a general feeling that the physical design of the building impacts on the way in which staff are able to communicate information regarding patient care as well as serving to maintain a split between the different professionals working on the unit. There were, however, two participants who did not appear to fit this notion of the building creating or maintaining a split between disciplines;

Jane: Yeah, or I go up and talk to the psychiatrists and Psychologists and I don't think that they [nursing staff] like that neither but now I've got so used to it that it's their problem, it's not my problem... No I just think if people are there, use them. If you want information, go and use that information... I just go and do it. Yeah. It's taken a long time to get to this stage. Let me tell you this, I've had a lot of you know, restraints.

It does indeed appear that the building design does not get in the way of this Healthcare Assistant. One possibility is that she has a clear idea of what her role is and that she is

there to engage with patients and that she will do whatever it takes to ensure that she can do this fully. However, when looking deeper into the interview with this participant, another possibility also seems to appear. She talks of having had to battle against her nursing peers to be able to put the patient at the centre of the care being offered. She often talks of nurses not wanting to take things outside the ward and that by doing so, she faced being seen as disloyal. The other participant who felt the building design does not pose a problem was from one of the social worlds perceived to be more powerful. The aspect brought to light by Sandra that staff who work upstairs have more freedom to move around the unit than those working downstairs, could go some way to explaining why they did not see the split levels of the building as a hindrance. It would appear that there might be something other than simple difficulty in transferring information from upstairs to downstairs and vice versa.

The possibility of territorial splits and the effect they have on staff perceptions of hierarchy and status-role splits are beginning to emerge as a potential factor in the difficulty associated with transferring information. The “real” inequalities that were discussed by Mary on the previous page could also be linked with this emerging idea regarding perceptions of hierarchy and status-role splits. If those who are perceived to be in an elevated position within the hierarchy are given more in terms of computers, offices, etc. then it is probable, as Mary suggested, that this could have an impact on whether people feel they are equal members of the team.

#### Separate vs. Team Working

Perhaps the difficulty faced by Jane could be looked at in terms of the difference between multidisciplinary team working and working independently. When I think of team working, I think about a group of people often from diverse backgrounds, working for “the greater good”. Something that is not a reflection on them or their profession, but rather using people’s knowledge and skills together to achieve an outcome. In this case, that would be all disciplines being able to put aside their differences or loyalties to focus on the best way to achieve a good treatment outcome for the patient. However, the following quote seems to suggest that this is not what is happening and that questioning how things are done is seen as being disloyal or “treading on toes”;

Peter: ...the communication that does take place is difficult because of the, well because people’s professional lives are at stake, really. So, if I say I

disagree with something or if I'm putting forward an idea, I have to be aware that that may contradict somebody else's way of working or somebody else's professional ideals or ideas and ideals actually.

This goes some way to explain the potential for different disciplines to feel threatened by team working, and how this might lead to a very closed and almost territorial approach to working with other members of the team. Hence making it seem quite intimidating to approach people from other disciplines and social worlds;

Sandra: But I do get the feeling that people upstairs find it intimidating down here and probably feel that it's not their space down here either. I mean there are some members of the MDT that I've never seen in the nursing office or very, very rarely... I think the nursing office can probably be quite intimidating.

If the different disciplines who are supposed to be working together to achieve the best patient outcomes, are not readily approachable, or perceived to be approachable then this has a clear impact on how effective work with patients can be. Although all disciplines are working within the same building to engage and treat the same patients, it is evident that a general sense of separateness pervades. Each discipline works within their own social world to discuss how they work towards engaging patients in order to reach goals that have once again been set within that same discipline. This can then result in a one dimensional view of a particular patient based on the experiences of a limited number of people, assessing the information they have in a particular way according to their training background. Without a "big picture" knowledge of the patient gained from as many sources as possible, it becomes difficult to fulfil the elements associated with patient engagement that have been discussed above.

Tom: I think every disciplines does have some supervisory structure so at that level, within discipline level it should be there but in between... Which is the kind of cross fertilisation benefit that we are, I think missing if we just stick to our own discipline.

Sharing ideas and information across disciplines would indeed appear to have a beneficial impact on how effectively all staff could engage with patients. However,

integration appears to be difficult to achieve. At the moment, although integration and teamwork is possible (as described by Jane), and is deemed to be truly fulfilling the patient centred aspect of engagement, it seems that this way of working is the exception rather than the rule. The four factors that have been identified in the data as being associated with inhibiting an integrative approach are; ambiguity/mystery, poor communication, criticism/devalued, reaction/blame.

#### **4.4b Ambiguity/Mystery vs Clarity/Demystification**

Another category that was identified as inhibiting patient engagement was a lack of clarity with respect to job role and function of the different social worlds as well as seemingly uncoordinated and inconsistent treatment goals for patients. Each of these will be discussed in turn.

##### Job Role and Function

It became evident that between the social worlds there was a sense of mystery about the role of each discipline with respect to patient engagement and treatment. The Nurses spoke not only of not having a clear idea of what the other disciplines did with patients and how they did it, but also of their own role in the engagement and treatment process. This lack of clarity about job role would appear to have a big impact on patient engagement; if you don't know exactly what you are meant to be doing then how can you engage a patient fully? This also creates the potential for resentments to build up between disciplines. If Nurses are not entirely sure of what their role is within the team then this can lead to them not feeling a part of the decisions that are made and the rationale behind them. This was talked about with particular reference to ward rounds where decisions are made about individual patients.

Sandra: ...Not always agreeing with the decisions made or not knowing the rationale behind the decisions that were made and we've got to sort of be that person to sort of communicate with them why those decisions were made. So obviously things can get distorted... 'cos they don't always make it clear why, what the rationale is, so you've got to kind of explain it to the primary nurse and the patient. So it's quite a difficult position to be in.

As well as the uncertainty about why decisions are made, there is also a sense of mystery with regards to what different disciplines do all day. There was very much a feeling that certain disciplines, namely those in the MDT, were seen to be people who only spent a small amount of time with patients doing something nice or fun and then just disappeared back to their offices. In general there was not a clear understanding of what people “upstairs” in the MDT were contributing in real terms to the job of engaging patients in order to reach a good treatment outcome. This resentment was found to be a potential factor in reducing the consistency with which a particular intervention or treatment approach was applied by nursing staff;

Angela: Yeah. It does feel like there’s a real split sometimes between the nursing staff on the ward and the people that are in the offices upstairs and sometimes get the feeling that it’s just two separate entities and we come along and we do something nice and then we leave and that’s the kind of feeling that and we don’t have to deal with the difficult stuff and it just, then that can become a big resentment... you need to be consistent... if we’re inconsistent, then it just doesn’t help the client

It becomes clear that if all members of staff are not clear about what different people do, why decisions are made and the impact that this will have on patient engagement, then it becomes very difficult to get a consistent approach that is understood by all. If staff do not understand why they are meant to be doing something with a patient, then it makes it difficult to explain the rationale to patients so that they understand and “sign up” to engaging with the treatment plan.

### Clear Goals

It has been briefly touched on that as well as not understanding the role and nature of the work of different disciplines, it appears that the goals of treatment for each social world are not necessarily unified and agreed upon by all members of the ward staff. This has big implications for the learning disability population where unity and consistency in approach are crucial.

Angela: I don’t think, I think we assume that we’re all working towards the same thing without actually checking it out and it’s only when you just start to

have a conversation that you think, it's quite shocking. I thought they were thinking the same way but actually they're somewhere completely different and it's not necessarily wrong but if I'm assuming you're thinking one way and you're not, it's never gonna work.

This clearly shows how the different social words can often be working in a very fragmented way with patients, each discipline coming in and doing their bit with patients without a sense of how this might or might not fit in with the bigger picture. More than that, it is often uncertain what the bigger picture actually is in terms of goals for engagement and treatment. Although a certain amount of difference would be expected (after all, that is why there are different disciplines involved in the care of each patient, to offer a holistic approach, applying our different skills and knowledge) if everyone is not heading towards the same end point then this can only create confusion and difficulties for the patient. Once again, if a patient cannot see the point or understand why they are being engaged in certain activities then this will ultimately mean that they will disengage from the process and be left feeling confused and disheartened.

Another crucial element of patient engagement identified was that of new learning and an evolving process. If there are not clear goals set out that have been agreed by all staff and the individual patient, with clearly identifiable aims and levels, then how will both staff and patients know when they have reached them and are ready to progress to the next level? One factor that became evident in the process of analysis was risk. To some disciplines, it appeared that the focus was on avoiding negative risk rather than promoting positive risk taking. When there is inconsistency and ambiguity at this level, it can become both frustrating for the staff and the patients alike and can become an area of contention;

Mary: Yes and that's where it can be quite frustrating again because there can be a very strong feeling on the ward that something needs to happen for a client... but the person who presented that at ward round was one of the few nurses that felt that he's not gonna be safe. So... there was another heated debate which was more or less divided 50/50 on the sort of danger of this client absconding versus the unhealthy time we spend in just sitting around...

It has been clearly demonstrated that if the staff do not have an understanding of the roles of their colleagues from different disciplines, then this can lead to resentments and misunderstandings which ultimately lead to inconsistent approaches with patients and difficulty applying the elements of patient engagement.

#### **4.4c Poor Communication vs Effective Communication**

Having just focused on the role of clarity in engaging patients, it is easy to see how this is associated with communication. Communication is one of the most important ways of ensuring that information regarding patients is transferred to the appropriate people at the appropriate time so that patient engagement can be achieved. The difficulties created by the layout of the building have already been touched upon but, do appear, to a greater or lesser extent to have an impact upon information transfer within the unit. There is also a sense that due to the fact that the MDT and all the disciplines that comprise it are physically close and readily available to each other, it makes communication easier;

Sandra: So we're not always aware of what's going on... and because people upstairs talk about these things all the time amongst each other. Do you know what I mean, even in passing it'll get spoken about, you know while they're making coffee, it'll get talked about, you know whereas we're really left out of the loop.

However, this is not the only problem associated with communication that has emerged from the data. It appears that communication within the unit is often a matter of chance; that the right person is there at the right time that holds a particular piece of information. This became particularly evident when participants spoke about the weekly ward round, which has already been mentioned in the above section on mystery/ambiguity.

Mary: It feels a bit like a game really with everybody throwing their little bits of information in and seeing if you can make anything out of it but whether you have the right information at the right time is a matter of chance really... You could happen to... know exactly what happened or

you're referring on information that's been passed on second, third or fourth hand...

Once again, it appeared that this was a particular concern of the Nurses as only one member of nursing staff attends the ward round to represent the nursing work that has been carried out each week with each patient. This was recognised as a problem not only by those from the nursing world, but by others in the MDT world that recognised that often the information being relayed was not necessarily a wholly accurate or complete reflection;

Peter: I feel that ward round that I'm in the parallel universe and that it's, in many ways a rather pointless exercise because I feel the real work goes on and doesn't, the real work goes on outside of the ward round and I don't think it's a very good reflection of that work.

This has an obvious impact on the decisions that are made in the ward round that directly affect the staff who will be implementing the decisions as well as the patients who are the object of the decisions being made. As Mary says, the decisions that are made about a patient's treatment depend on the information that is presented by all those present at the ward round. Once again it appears that the patient is not being put at the centre of the decision making process as they are not present at the meeting and the nursing staff who know them the best are also not necessarily present. This can then have a knock on effect, as described in the above section on clarity, of nursing staff and patients not feeling fully involved in the process and thus making it difficult to take ownership of the judgements that have been made about interventions that need to be carried out and the way in which engagement should occur.

Irene: it's (ward round) a little secret club where decisions are made that they (nurses) have no impact on and also, I know for a fact from feedback that I've had, that that's certainly how the service users feel, that it's a little group with the door shut, "you're gonna make a decision about my future or you're gonna give me feedback that says "no change" whatever that might mean. Without any explanation about how you've arrived at that decision"

This highlights the difficulty associated with the ward round and how the decisions are communicated to those not present at the meeting; both staff and patients. The above quote also appears to show the power differences between the MDT and the Nursing social worlds and how undervalued they feel in terms of being involved and listened to when it comes to making decisions about how patients should be engaged. This will be discussed further in the next section. However, perhaps it gives an insight into why some participants from the MDT world felt that no matter how many nurses were told about new interventions, they might not necessarily implement them;

Angela: I spend my whole time trying to figure out a good way of communicating something with people, you know if you set up a programme with somebody and how to work with it and telling everybody and writing it everywhere and doing it everywhere that I can possibly think of and yet it's still, "well I didn't know anything about that". It's like but I don't know how else to pass that across and I'm sure that must go the other way as well and it's just really messy.

#### **4.4d Criticism/Devalued vs Acknowledgement/Valued**

The above section on the difficulties in communication have alluded to the idea that certain groups of staff feel less valued and have less input in the decision making process than others and this is certainly something that has emerged from the data time and again with reference to various aspects of patient engagement. The main areas that will be discussed are criticism, the culture of blame, the notion of valuing ideas and how all these impact on the sense of ownership, belonging and empowerment.

##### Value

During each of the interviews with participants it became evident that value, acknowledgement and power were key themes that were associated with working with colleagues from a variety of disciplines in order to engage and treat patients on the ward. Once again the split between the Nursing, the MDT and Management worlds were highlighted and there was a strong link between the Nursing world and the process of devaluation and disempowerment;

Jane: My only issue with upstairs is... that sometimes it annoys me and it does annoy me, I'm not gonna deny that, is the fact that they see them for an hour a week and then they think that they know better than somebody that sees them for 37.1/2 hours a week and I think they should be more... open minded towards us as well and sometimes you know, if you asked us, maybe, perhaps maybe, once in a while we might know or we might know best rather than think that they know these people and they only see them for an hour a week....

This quote strongly appears to suggest that members of the Nursing world feel that what they have to say is not valued by the rest of the team as useful or important in terms of determining how best to engage patients or of having knowledge and information that might be of equal or greater importance to other members of the MDT world. However, although this sentiment was echoed many times by the nurses who took part in the interviews and from my own observations whilst working on the ward, the members of both the MDT and the Management worlds spoke of something slightly different;

Irene: Whereas, trying to strike a balance so that everybody feels heard, that can be quite difficult when you've got such a large group of people and I'm sure that there's people at, in the lower bands who sometimes don't feel heard despite the fact that you really want to offer them an opportunity, sometimes it's hard for them to feel that they can come forward when other people, they think are more senior or have more power are around

It would then seem that the devaluing is perhaps something that is felt by those in the Nursing world, but that does not necessarily emanate from other members of the MDT or Management not valuing their contributions. It seems that the nurses themselves do not always value the contributions that they could make to the decision making process and thus get caught up in the process of not putting their ideas forward;

Interview 2: So... now I come to think of it, the nurses know lots of things but they don't value it, they don't expect it to be valued by others but in fact they do know things. I suppose what I think happens to that knowledge is that they get caught up in the counter transference from the patients and

assume that they don't know things like the patients feel they don't know things, they get transmitted to the staff, nursing staff. So there's a kind of devaluing process, a self-devaluing process goes on.

However, although this alludes to the possibility that the devaluing process starts within the Nursing world itself and that this is based on the assumption that there is a parallel process going on between the nurses and the patients, it does not fully explain why this might be. One possibility is that due to this process, that many of the nurses assume that what they know is not as important as others within the MDT and therefore get caught up in going along with decisions that are made about the patients in their care;

Sandra: Well it's almost as if we tend to think that anybody that is upstairs is going to be more superior and has that right to make those decisions. We don't feel that we can't challenge them but I guess it's a subconscious thing, we kind of almost assume that, OK that decision was made in the ward round therefore, it's gotta be a good one.

This does appear to be part of the story, but not the full story of why nurses feel so devalued and disempowered.

### Criticism and Blame

One other key feature of the devaluing process appears to come from the fact that Nurses, as well as other disciplines, identified a culture of blame and criticism. Once again, this was linked mainly with the Nursing world. It became evident that the Nurses felt that much of the interaction between them and the Management world in particular was negative and critical and did not acknowledge the difficulties involved in working with such a complex client group;

Mary: We are, I mean we're here at 10 o'clock at night putting people in seclusion... So it's just, it's sort of seeing that and having it valued really and I think a lot of that is, not so much the other disciplines but more coming from the managers that what we'd really like is if the manager's came down and said, "you've done absolutely brilliantly this week, well done, you know you organised a party, you did, you coped with all the decorating, you've had, you know a patient kicking off, another patient

having an argument, it's all been handled, well done!" Just that simple and it doesn't happen.

What has emerged from the data is that the lack of praise and acknowledgement, coupled with a culture of criticising things that have not perhaps been done as others would have liked or according to strict protocol and procedure. And that seemingly less significant factors, such as ensuring the office is tidy, are felt to be picked up on whilst more positive aspects are felt to be ignored. This appears to have had a de-motivating effect on those who work in the Nursing world and affects how effectively Nurses might engage with patients and where they focus their efforts. It emerged that many Nurses spent a long time preparing care plans and other documents associated with patient care, as well as tidying and other such activities which distracted from the work of engaging patients.

Peter: I think people get told off or they get asked questions, meaningless questions, you know get disciplined, you know discipline with a small D or feel bad because they haven't, you know without any of the external structure, they just feel bad because they're not getting anywhere or they're, you know nothing changes or, you know the patient doesn't respond, "oh I got that wrong" and then there's no, go round in circles.

Many participants talked of the Nurses having a fear of getting blamed or into trouble if they did the "wrong" thing when engaging with patients and the quote below from the Management world acknowledges the difficulties that Nurses have when considering taking risks with patients and engaging them in therapeutic activities. Another aspect of this category that emerged was that each discipline as well as being employed and managed by the Unit and NHS Trust management structure, was also subject to the ethics and codes of practice laid down by their professional bodies. The nature of these codes of practice were discussed by some participants and appeared to be particularly central to the Nurses. That is, they spoke of them as a set of "do's" and "don'ts" that were very rigid and were often associated with risk, especially negative risk and how to manage it, who is responsible and what should not be undertaken with patients rather than considering positive risk taking and how best to support nurses in this endeavour. It was presented to me by one participant as a real conflict between wanting to engage patients and take positive risks and being constantly afraid of the consequences. This

appeared to have a detrimental effect on Nurses sense of power and appeared to be a large factor in the devaluing process. To make a decision and be responsible for the consequences was often seen as too big a risk and so either Nurses would say “no” when faced with a difficult patient request or would defer to the rest of the MDT so that the ultimate accountability if anything went wrong would not be solely theirs. Those in the Management world were aware of this conflict and found it a difficult one to know how to manage as it felt as though it was also beyond their control too.

Irene: I am not going to say “let’s go ahead and do this” because the consequences can feel too much ‘cos you’ve not only got your own professional body coming down on you, you’ve got HR, you’ve got the medics, you’ve got whoever else and the criticism of nursing is, unhealthy.

It would appear that there is indeed a devaluing process that goes on which affects and is in turn affected by the culture of blame and criticism. This appears to affect the Nursing world in particular. All of the aspects discussed above seem to reinforce the notion of those in the Nursing world that they are at the bottom of the hierarchy. The need for recognition and acknowledgement could in part be thought about as a product of this hierarchical split, with the nurses being kept in the child like role of desiring praise and having to ask permission and the MDT and Management in the parental role of being expected to give it. The effect that this has on patient engagement is vast. It has already been noted that if all members of the team working with a particular patient do not understand, agree to and have some sense of ownership over the decisions that are made with respect to patient care, they are less likely to apply interventions which leads to an inconsistent approach which is detrimental to patients and can have an effect on the quality of relationships that staff from all disciplines are able to engage them in.

#### **4.4e Reaction vs Reflection**

The final factor that impacts upon patient engagement is the extent to which staff react to or are able to reflect on the types of interactions they have with patients. It emerged from the data that the type of patients who reside on the ward are very complex in nature and often present with challenging behaviours that test the patient engagement skills of the staff to the extreme. All participants commented that sometimes patient

attributes impacted on the way in which they were able to engage with particular patients. These ranged from the extent of the learning disability to the degree of mental health problem. However, all staff also agreed that every patient could be engaged at some level no matter how unwell they were or how the learning disability affected their understanding. What did become apparent was that the way in which the patient's behaviour was interpreted and thought about by staff impacted on how they engaged with them. When talking about patients who are difficult to engage, one participant spoke of the following;

Tom: I think that [difficult behaviour] triggers a kind of vicious circle of staff becoming demoralised with this patient who is not engaging and kind of withdrawing and making this worse and more difficult for the patient to engage and so on.

What happens at this stage is then crucial in terms of being able to re-engage the patient and to work together with them to reach a good treatment outcome. However, it seems that it is at this point that many of the issues discussed above with regards to fear of being criticised and not valuing the information and knowledge that each person has, regardless of discipline, affects what happens next.

Jane: Yeah... your training will equip you for something but there's always gonna be a point I think when your training runs out, when you need to use a synthesis of things or things you've never thought about before or things that just test you. You know, oh my god I don't know how to cope with this, what do I do now and then you have to think and you might come up with the wrong answer or you might come up with the right or you know, whatever but I think people need a lot of support at that point and clearly what I think supervision is, is helping people with the bits that are not clear, when you think, oh my god I don't know what to do, I don't know what's happening here. At the very least saying, that's OK, nobody knows what to do.

The above quote highlights how factors such as poor communication and the fear of criticism and blame might hinder this process. If Nurses and other disciplines are scared of being criticised for saying that they don't understand or for being open about

mistakes that they might have made with patients, then it makes it impossible to have a clear understanding of the difficulties being faced and how best staff can be supported with the process of engagement.

Many participants talked about the fact the patients on the ward evoke powerful emotions in staff and are capable of “splitting” the team. Without a space to acknowledge this and think about what is happening with the patients and why they are making the staff from all disciplines, but especially those who work the most closely with them-the Nurses-feel a certain way and react a certain way to them, it is very difficult to know how to engage them most effectively. What can happen at this stage appears to be one of two things; a knee jerk reaction to certain challenging behaviours or an avoidance of engaging with the patient altogether, which triggers the spiral of the patient disengaging further and so on.

Angela: as a team I think how we decide what we’re gonna do and when just, depends on so many other factors, it’s not consistent. So, depending on who is in a group of people, what event has stuck most in people’s minds, whether it’s something last week or last year. What other events are around that make people want to do a knee jerk reaction... and people are so there terrified of something going wrong that nothing ever... It’s very frustrating..

The above quote was taken from a passage where the interviewee was talking about how patient’s behaviour is thought about and that quite often staff, at all levels, react to certain patient behaviours by either restricting their passes or classifying them as “risky” instead of thinking about what the behaviour was about and how it might inform how we engage with that patient in the future. It is, of course difficult when working with patients who exhibit violent behaviour not to factor in the safety of staff and other patients on the ward, and sometimes, restrictions and having a cautious approach is necessary. However, if this has been thought out and reflected on with staff at all levels, then it means that we are no longer reacting to, but thinking fully about the needs of the patient and how we can engage them most effectively.

#### 4.4f A System of Engagement

All of the factors that have been spoken about throughout this section show just how crucial staff feel that their relationships with other members of the team and also the organisation as a whole, are in the task of engaging patients. The findings that have emerged from the analysis have forced me to look at the unit that I thought was so familiar, in a slightly different light. By listening to and analysing the interviews, I have seen that my initial ideas as to what staff felt would impact their ability to engage patients were not always in line with those of my colleagues. This opportunity to do research where I work has enabled me to have a broader understanding of just how challenging it can be for everyone, regardless of professional background and “rank” to work together towards the end of maintaining and developing patient engagement. Because of this, I have come to understand that staff ability to engage patients is associated with how engaged staff are within the system or organisation as a whole. One of the participants summed this up very succinctly;

Tom: ...So [patients] would react by not engaging and trying then to engage a patient who is difficult to motivate, doesn't believe that he needs it in the first place is a bit more difficult and then that, I think that triggers a kind of vicious circle of staff becoming demoralised with this patient who is not engaging and kind of withdrawing and making this worse and more difficult for the patient to engage and so on... I think the main issue is to identify that this is happening because you can't really address it unless you're aware of the problem...

The diagram in fig. 4.4 shows patient engagement at the top branching down to either enhancing or inhibiting factors. Beneath the enhancing or inhibiting branch are the key categories that have been identified with each. The factors on the inhibiting side represent one end of the spectrum whilst those on the enhancing side represent the opposite end of the spectrum. All of the factors at both ends of the spectrum fall under the category of what I have called systemic features. What appears to be crucial to staff ability to engage patients is the level at which the system functions. A high functioning system that allows for clear communication, clarity and demystification, is reflective and acknowledges and validates all staff would be seen to offer the best chance of enhancing staff ability to engage patients. Whereas a low functioning system where

ambiguity, mystery and poor communication reign as well as a taking a critical, blaming and reactive stance, inhibits staff ability to engage patients. Although I have laid out these two opposing ends of the spectrum, it is important to remember that they represent an ideal and a worst possible case scenario. As with patient engagement, it has become clear that the level at which the system functions is not necessarily static, but can change over time according to how some of the factors within the system fluctuate.

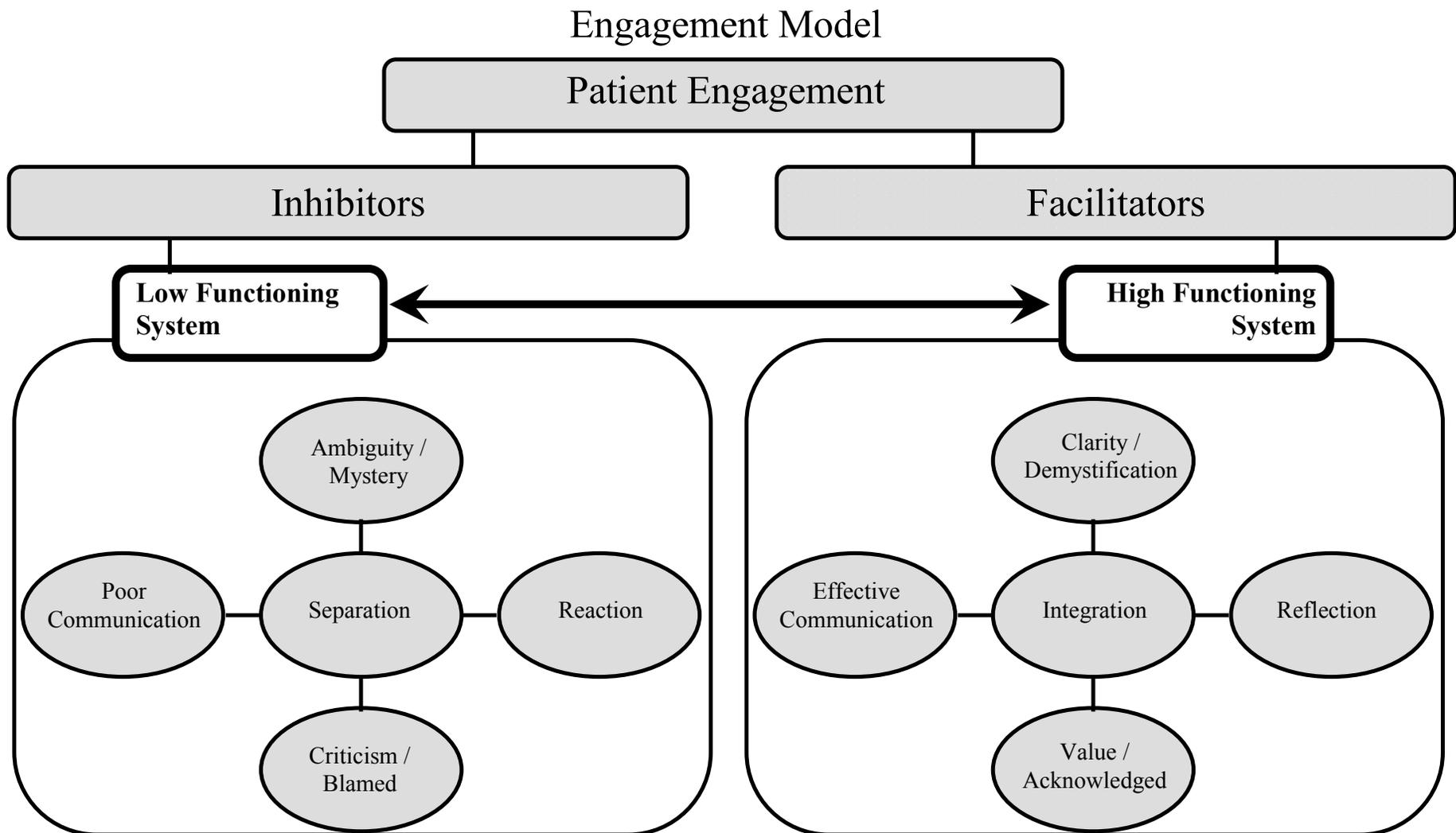


Fig. 4.4 System of Engagement

What is clear from the analysis is that all of the systemic features are related and are not stand alone categories. They are dynamic in nature and each one is likely to impact on some, if not all of the others. However, what this analysis has not been able to demonstrate is exactly how they are all interlinked. Throughout the course of the analysis I have made a variety of attempts to make the pieces fit together in a clear and final way, offering a model of how the systemic features function. It would feel very satisfying to be able to offer a complete model that explains exactly how one factor is affected by another and how this in turn affects the next factor in the system. To even offer a graded set of systemic features from most to least influential would be a leap too far. It is essential to recognise the limits that this piece of research can reach. That an overarching structure has been identified, but that the intricacies of the system need to be further assessed before any conclusions can be drawn as to the nature of causality.

What I have not attempted to show in the diagram is causality and for ease of reference and as no clear links emerged from the data, I have not explicitly shown the possible links from each of the outer categories to each other. Having said this, I have placed separation at the centre of the low functioning system and integration at the centre of the high functioning, as these themes emerged very strongly from the data and links to each of the remaining four categories were clear. Separation/integration pervades all of the other factors and appears to represent an “us” and “them” split between those who are perceived to be valued, knowledgeable and powerful-the MDT and Management-and those who are perceived to be undervalued, powerless and criticised-the Nurses. Everyone who was interviewed was aware of this perceived difference and all wanted to be able to work more effectively with their colleagues. The suggestions that were made to start to change this were deceptively simple;

Sandra: That’s why it’d be nice to sort of break down those barriers and for people to come a bit more so we all get used to one another’s faces, ...  
Yeah, I think people coming down will break those barriers down.

Tom: Yes because I don’t think that staff who work on the ground floor shouldn’t have access to whatever resources are upstairs. I think that it should be made available... (that) they are encouraged to actually use the space and approach people as they, who are upstairs and I don’t think

that it will need any more kind of complex intervention for this to be resolved to be honest

However, as simple as the suggestions seem to be many acknowledged the difficulties in breaking old habits and working more closely with people who might not share the same view or professional ideals that you do;

Angela: Yeah, and actually if you're working with somebody that doesn't really have a clue what you do and you don't with them and there might be a potential clash. Sometimes the best way to do it is to work alongside and understand that way, but it's not an easy thing to do.

Although some of the suggestions to create more clarity, and get people from all the disciplines more used to each other by working together and just generally leaving their own territories more often could happen relatively rapidly and see some level of success, I would imagine that the areas of communication, reflection and criticism and blame would take longer to change as they appear to be more ingrained within the working of the system.

## **5.0 Discussion and Conclusions**

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In the previous chapter I presented the results of my analysis and offered a model for understanding how staff define and construct the process of engaging patients and a model to explain the factors that staff perceive affects their ability to carry out this process of engagement. In this chapter I will further detail the process by which I generated the theories from the data in line with the constructivist approach. I will also discuss these emergent theories in light of the previous research that was discussed in chapter two and the implications that my findings have on service provision and on possibilities for future research.

### **5.1 Constructing Theory**

In line with my decision to use constructivist theory to drive the process of my research from interview to analysis, I have generated a theory that does not simply use core categories as a means of reducing the data to mere descriptions of topics, but that pushes beyond this to interpret and find meaning in how the participants talked about the processes involved with engagement and the actions that they involved. Charmaz (2007) describes how this enables the researcher to think about the consequences and relationships between these actions and construct an interpretation of the implicit properties of the category to enable meaning to become explicit. This is in stark contrast to the objectivist stand point which sees theory as a means of specifying relationships between concepts, explaining and predicting these relationships and verifying theoretical relationships through hypothesis testing. What these objectivist theories lack and what interpretive theories aim to achieve is an in depth understanding of the phenomena being researched. This kind of theory acknowledges subjectivity and attempts to offer an imaginative interpretation of the subject being researched.

In my interviews and subsequent analyses it would have been naïve to assume that I could take an objective stand on the topics being discussed by the participants, after all, it was my unique position within the organisation and my prior experience that enabled me to have access to participants as well as a subjective understanding of the phenomena I was researching. It is with this in mind that I present my theories of how staff construct the process of engagement with patients and what they feel impacts on their ability to achieve this. The situational context of this enquiry is also essential to

the theories that I am offering and the findings have been derived by studying not only the relationships and consequences of actions of the individual but also the actions of the collective. In this research that was achieved by examining how the process of engagement was constructed by the individual within the context of the organisation and looking at how this was negotiated amongst the different professionals within the context of the inpatient hospital environment.

## **5.2 Engagement as a Process of Relating**

Having outlined the theoretical underpinning of the process of arriving at the generation of a theory of patient engagement, I would like to turn my attention to the theories themselves. In the previous chapter I presented the theory that the staff working within the context of the inpatient psychiatric hospital arena with patients with learning disabilities and challenging behaviours construct the process of engagement as one that is based on being able to build a relationship with the patient.

It quickly became clear that the staff I interviewed seemed to take for granted that patient engagement was an essential part of being able to work with patients to meet good treatment outcomes. Yet when they were asked to expand further on this to try and explain exactly what they meant by engagement, how they achieved it and why they felt it was so important, the task seemed all of a sudden to be less clear and more complex. The three categories that my analysis identified as important to staff in the process of engagement were:

- Relational Elements
- Levels of Engagement
- Evolving Process

These three categories of engagement will be summarised and discussed in relation to the previous literature that was reviewed in chapter two and with a view to highlighting the implications for further research and theory and service development that have arisen as a result of my findings.

Participants were all able to agree that it was important but arriving at an explicit account of how they constructed the process of engaging with patients often required them to draw on examples and present narratives of what it was like to work with a particular patient, how they had gone about this and what they felt had been important to that particular piece of work. Through this process participants quickly began talking

about the relationship and how important it was to build a relationship with the patient. What also emerged was that this relationship was not just a preamble before “proper” engagement in activities could occur, but was an integral part of the process of engagement. In fact, the relationship or relational elements as I referred to them in the previous section, were seen to underpin the whole notion of engagement. When I reflect on my own experience of working with patients I can see that the relationship is at the corner stone of how I go about things. Yet, this came as something of a surprise to me when interviewing my colleagues from different professional backgrounds.

I had thought that how participants constructed engagement would be dependent on their professional background and would revolve mainly around the types of activities or sessions that a professional offered a particular patient. Although participants did talk about activities, tasks and goals, this was done so when exploring how the relational elements gave rise to being able to develop an understanding of the individual which allowed for goals to be set that had clear meaning for that particular person. This notion of the relationship being a constant overarching feature of engagement was evident when identifying the other two major factors in how staff construct the term engagement. The levels of engagement and the evolving nature of engagement were inextricably associated with the relational elements and with each other. That staff should be able to respond to the changing needs of the individual patient was seen as crucially important to providing engagement that would promote new learning and development and allow for optimal treatment outcomes.

However, being able to identify this was seen as an outcome of having spent time getting to know the patient and building a relationship with them. This in turn allowed the staff to establish the level at which the patient could become involved in matters of decision making about their care and which goals to work towards that would hold meaning for the individual. The relational elements were seen as important to not only recognising when to move towards a higher level of engagement which involved more challenging goals and greater input in decision making, but also at being able to detect any deterioration in patient functioning at an early stage so that goals could be reassessed promptly and any necessary action taken (new medication, implementation of management plans or increased access to certain activities or one to one time) to limit the possibility of disengagement.

This finding suggests that the therapeutic relationship lies at the heart of how staff from all mental health professional backgrounds construct the term patient engagement. This certainly supports the literature that was discussed in chapter two that has found that the therapeutic relationship is considered to be a crucial aspect in reaching optimal treatment outcomes. This finding also extends what is already known about the importance of the therapeutic relationship within the world of inpatient mental health services as it gives new insight into how the relationship functions to enable staff to provide levels of interaction that are meaningful for the individual. With participants in this study clearly placing the individual needs of the patients at the centre of their construction of the term engagement, it reinforces the idea services for people with mental health problems and learning disabilities are moving toward a more person centred approach to care and treatment. To what extent this is true is unclear from this aspect of the research, but it certainly suggests that mental health professionals know what they should be doing and know what they think is important. Whether service provision truly reflects this will be discussed later in relation to the findings of the second part of this enquiry.

Another area of previous literature that can be reassessed in light of this finding is that concerned with patient activity levels and boredom. On the basis of this finding, it could be suggested that the relational elements of engagement could be seen not as only as the basis for engagement but also as a mediating factor. If we consider that staff in this research felt that the relationship was key to being able to respond appropriately to the changing needs of the patient and to having some knowledge of how they react in an array of different circumstances, then it could be suggested that the absence of the relational elements could be associated with an increase in violent or aggressive behaviour by patients, as in Meehan et al.'s (2006) study on boredom and activity levels in secure forensic wards. If the function of the aggressive behaviour was an attempt to gain attention (as was discussed in chapter two) then having built a therapeutic relationship could be a crucial factor in reducing such behaviour. The relational elements could facilitate staff to make an appropriately timed intervention that is based on having a knowledge of the patient and being able to "read the signs" a patient is giving before hand. This would all need to be based on information gathered about the function of the behaviour through a functional behavioural assessment, which can only be strengthened by having a good relationship with the patient in question. However,

further research would be needed to ascertain whether and to what extent the quality of the relationship could mediate violent behaviour.

### **5.3 Social Worlds/Arenas Maps and What Affects Staff Ability to Engage Patients**

Although my findings that the relationship is central to how staff construct the process of engagement offers a valuable insight into what staff view as important in terms of the treatment they provide to patients, it does not ascertain what impacts on their ability to build these relationships and deliver the patient centred care that they all spoke of. This brings me to the next aspect of my findings that I would like to discuss. In the previous chapter I presented the theory that staff ability to engage patients within the context of an inpatient ward for people with learning disabilities, challenging behaviour and mental health problems could either be enhanced or inhibited by the level of functioning of the system they are working within. This means that participants spoke broadly of systemic or organisational factors that they felt impacted either positively or negatively upon their ability to build a therapeutic relationship with patients.

The categories that I identified as associated with a low functioning system and thus inhibiting staff ability to engage patients were:

- Separation
- Ambiguity/Mystery
- Poor Communication
- Criticism/Blame
- Reaction

The categories that I identified as associated with a high functioning system and thus facilitating staff ability to engage patients were:

- Integration
- Clarity/Demystification
- Effective Communication
- Acknowledgement/Valued
- Reflection

These categories emerged from the data when participants were talking not only about what they felt impacted their ability to engage patients on the ward but also from the narratives they gave of how they think an ideal ward would function and the impact this would have on both staff and patients alike. I present the categories associated with the low functioning system as representing one end of a spectrum with the categories associated with the high functioning system at the other, rather than presenting them as an “either”/”or” state of affairs. I also propose that the categories within the system are dynamic in nature and that whilst certain organisational cultures and policies might predispose an organisation to sitting overall at one particular point along the continuum, the position could fluctuate to a certain extent. In other words, certain systemic factors could vary, even on a shift to shift basis. For example, participants spoke about how they could have a “good” shift where they were working with people they felt they could communicate openly with and had a clear view of the goals each of them were working towards on that day. However, on a “bad” day they could be working with people who they felt they could not communicate effectively with and who they feared would criticise them. This shows how, in the short term, the level at which the system functions can alter depending on relatively minor changes, for example, the level at which a small group of staff communicate, in the long term, the culture and operational policies of the organisation are likely to have more of an impact on the level of functioning.

How this impacts on staff ability to engage patients is not necessarily immediately apparent. However, what emerged from the data was that each of the above categories within the low and high functioning systems did indeed affect how participants felt they could engage patients within a therapeutic relationship within the context of the ward situation.

### **5.3a Separation vs Integration**

The social worlds/arenas map that I presented in the previous chapter clearly shows the different worlds that are working within the unit, the areas of communication between them and the power differences that were perceived to exist between each social world within the arena of the inpatient unit. Participants continually referred to both the physical separation created by the design of the building which consisted of those within nursing world downstairs on the ward with patients and those within other

disciplines within the MDT world upstairs with separate offices for each discipline. The separation they felt existed between each of the disciplines working within the unit was also talked about in relation to this physical split but also in terms of each discipline being perceived as working with patients in a separate way instead of everyone working together to achieve common goals. It was felt by some participants from both the MDT and the Nursing worlds that the physical design of the building reflected and reinforced the notion of a hierarchical system with management and other disciplines at the top making decisions about patient care that would have to be enforced by nurses. Participants felt that if they worked in a more integrated way then it would enhance the way in which information was shared between disciplines, would reflect a less hierarchical organisational structure with decisions being made on the basis of teamwork rather than power. They felt that this in turn would improve the way in which they were able to engage patients.

### **5.3b Ambiguity/Mystery vs Clarity/Demystification**

Within this category there were two main areas of ambiguity and mystery that were discussed by participants. The first relates to not having a clear idea about the roles and responsibilities of various different professionals working within the unit. Participants described feelings of uncertainty over what other disciplines were meant to be doing and how this fitted in with their own work with a patient. This was talked about as leading to confusion and certain resentments between those who were perceived to be carrying out “nice” activities with patients and those who were left to pick up the pieces (nurses). The lack of clarity regarding goals was also seen as a problem by staff who felt that without a clear idea of the goals that all team members were working towards, work with patients could become quite fragmented, tokenistic and ultimately confusing for the patient as there was no clear common goal. This could also ultimately lead to violent and other challenging behaviours.

### **5.3c Poor Communication vs Effective Communication**

Poor communication was seen to affect patient engagement in many ways. Participants talked of information being shared freely amongst the various different staff groups within the unit and how this affected the decisions that were made regarding patient care. The decision making forums, i.e., ward rounds and other meetings were not

necessarily attended by staff who were most involved in a particular patient's care and who would thus hold the most information about the patient. An element of chance in communication was talked about consistently by participants. It also appeared that the split between the two main social worlds, the MDT and the Nurses, was again highlighted in this section. There appeared to be an almost territorial aspect to how information was shared amongst staff with fear of being punished being the driving force behind the Nurses not sharing information between other MDT members. Every participant said that they would find it so much easier to engage with individual patients if everyone in the staff team could just communicate more effectively and make sure that up to date information was available so that staff could adjust their approach with patients accordingly.

### **5.3d Criticism/Blame vs Acknowledgement/Valued**

This category was seen to be associated with the category of communication as many participants acknowledged that a fear of being criticised or blamed for something was interfering with how willing staff were to communicate with members of the wider team. Staff from all social worlds recognised that it was the nurses who felt this most keenly. The perception of where this emanated from, however, differed between the social worlds. Nurses felt that it was the Management and to a certain extent other members of the MDT world who were most to blame as they were perceived to be very critical of the nurses and did not acknowledge the difficulties being with patients all day posed to these staff members. The Management and MDT worlds both acknowledged that the nurses were often in the "firing line" of criticism but they felt that this was more associated with the existence of so many policies and guidelines issued by the Nursing professional bodies that focused on the risk of losing their registration if anything bad happened. Those in the MDT world also pointed out that a lack of support for nurses from their own discipline led to them becoming very fearful of other members of the team. This affected the way in which they communicated with each other and with wider members of the team as well as having a direct impact on the activities that they were willing to carry out with patients. Nurses pointed out that if they were only going to get criticised for something and not acknowledged or valued for the positive steps they made with patients then it made them feel less inclined to "go the extra mile" for the patients. Again where this feeling of being devalued originated was looked at in different ways by participants. Nurses feeling it came from Managers and other

clinicians, the Managers feeling it came from the professional bodies and the MDT suggesting that because of this long process of being devalued by both management and policies, Nurses no longer value themselves and the contributions they have to offer to the team.

### **5.3e Reaction vs Reflection**

This category was seen by participants as representing one of the major frustrations within the organisation. Staff talked of the organisation and individuals within it as being very reactionary rather than reflective. This emerged in relation to participants talking about the complex and challenging nature of clients on the ward and the difficulties that were associated with working with such patients. This could be seen as a by-product of the general lack of consistency around patient care and the range of different approaches taken by staff. Although the degree of learning disability, type of mental health problem and variety of challenging behaviours presented by patients were all discussed by the staff who were interviewed, there was an implicit acknowledgement that this was what they had “signed up for” and that these factors in themselves were not necessarily the problem. What participants did feel was a problem was the way in which all the members of the various disciplines either reacted to or reflected on these difficulties. There was a general consensus that even the most challenging patients could be engaged at some level as long as all members of staff were able to come together and think about the function of the challenging behaviour and how best to try and engage the patient. This ranged from a general sharing of knowledge or “tips”, what has worked with other staff members and a particular patient. The factors associated with poor communication, fear and feeling devalued were considered to contribute to the lack of reflectivity on the ward. When reflection did not take place it was considered by participants to be the beginning of a dangerous spiral that could ultimately end up with staff disengaging from the difficult patient and the patient disengaging from the system.

### **5.3f The System**

The key categories of what I have termed the system have been outlined above and in greater depth within the previous section. How this system affects staff ability to engage patients has been clearly stated. Yet, how these categories within the system are

related to and impact upon each other has not been clearly identified. Throughout the process of the interviews and analysis it emerged that organisational or systemic factors were seen by the participants to affect the way in which they felt they could engage with patients. As the analysis progressed I tried many ways to piece together the categories of the system into a logical manner that should clearly show how each one impacted and was impacted upon by other categories within the system. However, this soon became a frustrating task as I realised that although the data gave rise to associations between the categories, it was not able to offer enough information as to how these categories were related or even to present a graded hierarchy of the most through to the least important aspects of the system.

What did arise clearly from the data was the idea that separation versus integration pervaded all of the categories within the system, which was represented in the separation and limited areas of negotiation between social worlds and the emergence of how this separation impacted upon staff ability to engage patients. It emerged that the complex power dynamics between social worlds as well as the design of the unit itself impacted upon this separation and the separation in turn maintained the hierarchical and physical distance between each world. For this reason, separation and integration were placed at the heart of the systems with other categories radiating out from them. Although I have outlined the finding that the other categories are associated to each other, I have gone no further in attempting to show causal links or explain exactly how each is linked to the other categories. To do so, would have meant stepping out of the interview data and stepping into conjecture and my own subjective theories based on prior knowledge, both theoretical and experiential. It is essential that I accept the limitations of this piece of research rather than be drawn into presenting theories that are not wholly grounded in the interview data. In being able to accept the limitations of this research it has enabled me to more fully consider how my findings could be used and the implications they have for future research and service development.

#### **5.4 Implications of the Findings**

Having summarised the main findings from this research it is now possible to consider the implications both in terms of how this informs and extends the current body of literature and how service provision and development could be informed. I have already clearly stated one of the major limitations of this research and that although I

have been able to offer a theory of that shows that the organisational system within which staff works affects their ability to engage patients, I have not been able to clearly show exactly how the categories in this system are related to and impact upon each other. Before discussing these limitations further and presenting implications for future research I would like to discuss my findings in relation to the current literature base.

In Chapter two I outlined the research relating to five major areas; client centred care, boredom and engagement in activities, the therapeutic relationship, staff and organisational factors and the social environment of hospital wards. I will now discuss how my findings on patient engagement are linked to and can extend this body of evidence. When outlining the findings of the first part of my research on how staff construct patient engagement, I discussed how this linked with what is already known about the importance of the therapeutic relationship. I also touched on the finding that staff perceive patient engagement as the most important aspect of their work, and how this could suggest that as a profession, mental health and learning disability staff have taken on board the need for client centred care to be provided. However, although all the individual professionals perceived client centred care to be essential, the second part of my findings suggests that the organisation within which these professionals worked struggled to support the staff in this endeavour.

It would seem that the difficulties lie not with a difference in perspective of the importance of client centred care to the different groups of mental health professionals, but in establishing effective ways of working together to achieve this end with the support of the organisation they are working within. My findings support those of Hatton et al. (1997) who showed that organisational factors such as staff support and clear operational policies and goals have a positive effect on staff stress and morale and therefore their ability to work effectively with clients. The participants in my research talked about the importance of these factors to them and I also found that their narratives offered a depth to my understanding of the difficulties of working effectively as a member of a broader multidisciplinary team to provide patient care.

As I discussed in chapter two, there has been an extensive amount of research into understanding how teams function and the difficulties of working within multidisciplinary teams. Once again my findings support this evidence base. In particular West's (1994) research into the effectiveness of teams and the role of support

from within the group for the group as a whole and for individual team members and the need to set clear goals that each member of the team understands and knows how to work towards. My findings showed that participants often felt unsure about the overall goals that the team was working towards with individual patients. As participants often cited a fear of communicating this uncertainty and feeling frustrated with the general lack of support that they felt they received in establishing a group understanding of the needs of patients, they often ended up working in very separate ways on separate goals with patients. This in turn impacted on all the other areas of blame, communication, ambiguity and reactionary behaviour.

This separation was fuelled by misunderstandings about who was meant to be doing what and there was a general sense of mystery over what each professional's role was and how their work with a patient contributed to the overall treatment of patients. Hatton and Emerson (1993b) found that this role ambiguity and role conflict can have a negative impact on staff stress and on the treatment outcomes of patients. The findings from my research support those of Hatton and Emerson (1993b) and also extend them by showing how role ambiguity acts as part of a larger system that inhibits the way in which staff feel able to engage patients within a low secure mental health in learning disability service. Another factor that Hatton et al. (1997) found was that when staff from all levels felt that they were an active member of the team and could directly contribute to the organisational policies which guided the day to day running of the residence, they became more invested in the organisation and contributed to the effective implementation of offering more activities to residents. My research also highlights the difficulty of involving all members of the team in decision making about operational policy as the fear of being punished or criticised affects the willingness of staff to communicate their thoughts and suggestions. Thus, serving to alienate certain sectors of staff who feel their opinions are not valued. I found that this affected staff enthusiasm for engaging patients as they did not feel connected to the decision making process regarding certain activities they were meant to be doing with patients. These findings also support the notion that job satisfaction has an affect on patient outcomes (Rose, 1994). In particular, the findings from my research show how feeling devalued and alienated from the decision making process can negatively affect staff motivation to effectively engage patients.

The literature associated with the social environments of wards has shown that patient outcomes can be associated with the atmosphere of the ward in which they are residing. The scale that Moos and Houts (1968) developed to assess the social environment of the ward focused on a number of different aspects which are outlined in chapter two of this research. The findings from my research could be discussed with reference to the work carried out on the social environment of psychiatric wards. In particular, in relation to aspects of how good the ward is at promoting relationships between staff and patients and how clearly the nature and aims of the programme (ward) are understood and communicated by staff and patients alike. Although the literature offers some slight deviations, in general a more therapeutic ward is one that offers, amongst other aspects, good opportunities for patients to build relationships with staff and has clearly understood aims which allow both staff and patients to work towards a common goal (Rossberg et al., 2006).

The findings from my research show that although staff consider the building of a therapeutic relationship to be crucial to engagement and thus patient outcomes, the lack of clearly defined goals that all staff could support patients to work towards was seen as an important factor in what affected their ability to engage patients. It could be suggested that how therapeutic the social environment of the ward is, could be highly associated with how effectively the organisational system functions, which in turn affects how well staff are able to engage patients. However, at this stage it would not be possible to draw such conclusions. Further research would be required to establish the exact role the systemic factors play in rendering a ward environment more or less therapeutic.

#### **5.4a Implications for Service Development**

So far I outlined not only how my findings are associated with previous literature, but also how my findings extend what is already known about how staff construct the process of patient engagement and what they feel impacts upon their ability to engage patients within the context of a specialist inpatient mental health and learning disability service. What is left is to consider how these findings could impact on service provision for this specific client group and how further research could promote our understanding of how services could be developed in order to offer the best possible chance of gaining good treatment outcomes.

I consider that the possible implications for improving the way in which services are run are substantial. Although only a small scale study of one specialist mental health in learning disability service, I believe the findings offer a valuable insight into the nature of the complexities associated with multidisciplinary team working within the NHS and how it can both positively and negatively impact on an individual staff members' ability to engage patients in a therapeutic relationship. On the basis of my findings it would appear that there are several factors that can affect how well staff feel able to engage with patients;

- Separate versus integrated working
- Ambiguity regarding roles of each discipline and goals relating to the organisation and individual patients versus clarity in all aspects
- Poor communication versus effective and open communication
- A critical and fearful culture that devalues staff versus a culture of valuing all staff contributions and acknowledging good work
- Reacting to difficult situations versus reflecting and understanding difficulties before acting

In the light of this research I would suggest that the main question that service providers and commissioners alike need to ask is how can services provide patient care that is truly person centred? The short answer to this, I believe, is by planning services that allow staff from a range of professional backgrounds to work in an integrated way. These services would need to ensure that staff have a clear idea of not only their own roles and responsibilities but also those of other members of the team and how they can work together towards goals that have individual meaning for patients. Effective communication should also be at the heart of these services, allowing all members of the team to have a voice and to feel that their contributions are valued. The organisation should also encourage reflective practice where difficulties can be thought about before reactionary decisions are made.

Despite the fact that the realities of designing and providing such a service are more complex than just saying that these are the way that services should be run. And, that in practice, government run services such as the NHS often have to ensure that they comply with a vast number of policies that may or may not hold particular relevance for an individual service, such as the one discussed in this research; it is likely that small

but achievable changes could be highly effective at creating an environment that fosters patient engagement.

It is still important to bear in mind that staff are having to keep up with a large number of ever changing directives that, although issued to ensure that standards are maintained across the NHS, can often cause added pressures for staff. Whilst there is the potential that they could serve to divert staff from direct patient care or put staff in a position where they feel conflicted about wanting to spend more time with patients but having to ensure that administrative tasks are carried out, this does not necessarily have to happen. Despite all of these pressures which most of the participants talked about, the consensus view was that as much as staff would like to see changes in these areas, they accepted that the NHS could be a bureaucratic organisation and that what they really wanted was to be supported to manage these constraints by their teams and managers. In addition to this, they wanted to be able to find ways of working together more effectively to ensure that client centred care was achieved.

One thing that I feel needs to be made very clear at this point is that the setting that was explored in the interviews with participants already operates at a fairly high level. Staff are already aware of the importance of putting patient needs first and offer a wide range of possibilities for engagement in activities. This raises the question of how representative the findings from this study are to other settings and whether the systemic factors would also hold as much importance in settings where engagement was very low or when multi-disciplinary teams were not working “on-site”. Although the small scale and qualitative nature of the research were never aimed at producing a set of results that could be generalised in the quantitative sense, it was designed to offer an in-depth insight into the phenomena of engagement; thus, opening up areas of significance that could be relevant regardless of setting.

It is likely that different settings might vary in their physical layout and make-up of staff (multi-disciplinary team on site or community residence made up solely of nursing staff and managers), but the idea of the system and how different social worlds might impact on this holds true. In community residences, whilst the on site team might be made up solely of nursing staff, they would still interact with either the community learning disability team or community mental health team which could fulfil the role of the “upstairs” or “MDT world” in this study. This in turn would mean that the systemic

factors found in this study would still be likely to impact the effectiveness of patient engagement in such residencies.

In environments where patient engagement is low and where this is not currently prioritised by the staff and the organisation, being able to offer a theory along with practical suggestions for changing the status quo would seem invaluable. What should be borne in mind is that the emphasis of any intervention is likely to vary depending on the current level of engagement that is offered. In practical terms, what this might mean is that an organisation that is offering high levels of patient engagement and where staff motivation to do this is high, an intervention might focus more on refining elements of the system to ensure that staff are supported to engage patients at an optimal level. However, in settings where engagement is minimal, any intervention would require a fundamental re-assessment of all systemic elements (i.e. structure of organisation, policies and procedure, etc.) as well as offering education regarding the importance of engagement in addition to supporting staff to implement techniques such as active support.

When it comes to looking at practical interventions that could be implemented, the suggestions of the participants are probably the best place to start when thinking about how services could be changed. Encouraging staff from all disciplines to gain a clear understanding of each other's roles would be a good place to start as it would enable a dialogue to be opened between professionals that could increase the effectiveness of the communication. It could also help to dispel the culture of us (nurses) against them (MDT) by fostering a culture where collaboration is seen as a mutually beneficial process which supports everyone to do their own job more effectively and would result in increased levels of patient engagement because of this. Implementing care meetings which involve the patient and key members of the team involved in their care would also enable better communication and encourage professionals to integrate better. It would also enable the team to truly work in a patient centred way by listening directly to the needs of the patient and forming goals together with them rather than simply based on what the professionals think is best. These strategies would enable the barriers between the disciplines to be slowly eroded and would go some way to reducing the hierarchical feel of the present system. It is also likely that by doing this, some of the fear of being criticised would also lessen and enable communication to flow more openly across disciplines, especially from the nurses to other members of the MDT.

Another simple, yet highly achievable and effective way of bringing staff from all disciplines together to form a common way of perceiving patient engagement is to carry out a functional behavioural assessment. Using this kind of tool allows for all staff to be involved in the process of understanding patient behaviours. This could help to improve communication between social worlds as there is no one person who has control over it. For this kind of assessment to be effective, everyone in the team needs to be involved in not only the observation of patient behaviour, but also in analysing the meaning of that behaviour and generating positive strategies for working with the patient. Perhaps most importantly, it places the patient at the centre of the care being offered, whilst encouraging staff members to work collaboratively.

I think of the above strategies as low level or first line tactics that would allow for higher level changes to not only be made but to be effective. It is likely that without changing some of the more basic aspects of the system, like outlining and modelling job roles to other team members and creating opportunities for different disciplines to work more collaboratively, staff would not be able to make effective use of interventions that require a certain level of communication to be in place. In particular, I am referring to the effective use of one to one and group supervision and reflective staff support groups. For these to work effectively then staff must feel able to communicate openly without fear of being punished or criticised. Such reflective practice has been proven to be useful in other settings where staff come into contact with extremely challenging patients as it allows them the chance to think about how they are working with a patient and whether they could be doing things differently to achieve a better outcome. Services for people with personality disorders that are run along therapeutic community principles are a good example of how reflective practice can aid the way in which staff engage with patients and thus have a positive impact on treatment outcomes (Haigh, 2002).

Indeed, since starting the interview process with participants there have been some changes put in place by the staff group that work within this unit. One of the staff who took part in this research took up the challenge to get staff communicating more effectively and placing the patients at the centre of their care by approaching a few key members of each discipline and implementing a protocol for multidisciplinary care meetings. These meetings involve not only the members of the multidisciplinary team involved in the patients care, but the patient themselves. Although it is still early in the

implementation process, the informal feedback has been positive and having been personally involved in one of these meetings, I have experienced how my own communication with other professionals in that particular meeting has improved. It is important to remember that this is only anecdotal evidence and further research would be required to assess the effectiveness of this intervention.

A final point that I wish to consider in this discussion is the way in which professionals are trained and how their training could incorporate some aspects of this research. I am referring, in particular, to two aspects; matters of power and matters of team working. The two of these, in my opinion are inextricably linked and the findings from my research show that perceived inequalities of power can have a destructive effect on multidisciplinary team working. It is an accepted fact that NHS services should be “joined up” and should give the patient the opportunity to have a range of professionals involved in their care. However, a truly collaborative approach requires old fashioned hierarchies of power to be discarded. My findings show that staff within the nursing world of the inpatient arena still felt disempowered. This was a feeling that was recognised by all professionals involved in this research and who felt that it needed to be addressed both at the level of the organisation (by encouraging nurses to attend MDT meetings, work more closely with other professionals and take part in training), it also needed to be addressed as part of their training and through a re-examination of the long list of codes of practice that they had to adhere to for fear of losing their professional registration.

#### **5.4b Implications for Further Research**

Although I have made some suggestions throughout this discussion section I think that the recommendations for future research should be explicitly stated where there is little chance of them getting lost within the narrative or overlooked. Although I believe that the findings from this research advance the body of literature on both engagement and how the functioning of staff systems can affect it, I must also acknowledge the limitations of this research and the implications they raise for further research. In using a qualitative approach to analyse the narratives of the staff working within a specialist mental health in learning disabilities inpatient unit, I accepted that the findings would not be generalisable in the quantitative sense. What I lost in being unable to generalise

across situations, I gained in being able to offer an in depth insight into exactly how the process of engagement is constructed by staff and what affects their ability to do it.

However, I think that my findings on the relationships involved between the different categories of the systems has opened up how little is known about how these various organisational factors operate. Further research would be useful in ascertaining exactly how the categories are linked, the findings of which could enable interventions to be put in place that would target specific problem areas within the system rather than having to try and break a seemingly vicious cycle. I think that repeating the current research across different types of inpatient settings would offer a further view of whether similar systemic features exist and whether they are deemed to be important in staff ability to engage different types of client groups. It is possible that the systemic features only really impact upon staff ability to engage the most complex and challenging of patients, but without further research in different arenas this could not be established. One other key area that I think would be useful for staff working with challenging and sometimes violent patients would be to look at whether the relational elements of engagement could be a mediating factor in violent and aggressive incidents. Although my findings suggest that this could be a possibility, it would require further examination.

#### **5.4c Implications for Counselling Psychology**

Before I offer my final conclusions I would like to consider how my findings impact specifically on the world of Counselling Psychology and other applied Psychologists working within the NHS. In 2007 the British Psychological Society (BPS), in partnership with the National Institute for Mental Health in England (NIMHE) and Care Services Improvement Partnership, issued the document *New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams*. This document emphasised the important role that all applied psychologists have in becoming an active member of the multidisciplinary team that they are working within, ensuring the good functioning of the team and supporting other team members to have a more psychologically minded approach to interventions in their work with patients. The findings of my research add to the existing knowledge that Psychologists should be using to ensure the good functioning of their team by showing how the system which staff work within can affect their ability to offer the best level of engagement possible to patients.

It is important that Psychologists remember that their role is to act as facilitators for change, growth and development, be that at the level of the individual, the group or the level of the organisation. My research findings stress the need for someone within the organisation to take the lead on ensuring that the system functions as well as is possible and it would seem that the Psychologists who are already within the team are ideally situated to take on this role and act as consultants for change within this unit.

## **5.5 Conclusions**

I feel that it is both necessary and important to bring this research to a conclusion by once again stating my main findings. I discovered that all the participants talked about engagement as a process of relating. That by building a relationship with patients they were able to establish clear goals for treatment that had individual meaning for the patient and be able to recognise and rapidly respond to the changing needs of the patient. However, it should be stressed that unless everyone has a collaborative goal, engagement such as this, at a macro level is, at best, likely to be ineffective and at worst, unethical. The second main finding was that staff felt their ability to engage patients was either enhanced or inhibited by the level at which the system they were working within functioned. The implications for future research and potential service developments have all been discussed within this chapter as well as how my findings relate to and extend the existing body of literature. One final point that should be noted is that although the findings from this study could well be applicable to other service settings, this is a relatively small scale study. The findings should be seen in that context and as a starting point for further exploration.

## 5.6 References

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## **Section 2: Professional Practice**

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### **6.0 Working with the Transference: Rebuilding the Trust after Past Mistakes**

#### **6.1 Introduction**

All identities throughout this process report have been changed to protect the anonymity of my client. I have chosen to write about Emily who is a client of mine at a low secure in patient assessment and treatment unit for adults with a mild learning disability, challenging behaviour and some forensic history. Emily has a diagnosis of borderline personality disorder and a low IQ in the borderline range. Working with Emily in this setting has presented me with numerous challenges and has provided a wealth of experience.

#### **6.2 Theoretical Framework**

A psychodynamic approach was taken to the work with Emily. This was decided in light of the broad base of literature that suggests that a psychoanalytically informed therapy that uses the relationship developed between therapist and client to explore the client's own fragmented sense of self and build a more integrated sense of self and object relations, is beneficial for people with a borderline personality disorder (Kernberg, Yeomans, Clarkin, & Levy 2008). A psychodynamic approach has also been deemed appropriate when working with people with learning disabilities (Sinason, 1992).

Despite these indications for using this framework, the issue of power and whether a relationship could be made with Emily that would not be prematurely ended either by the length of her stay or my contractual obligations, needed to be carefully considered. When addressing the first issue of power, Sinason (1992) states that this is something that should be made explicit when working with learning disabled clients and should be borne in mind throughout the therapeutic process. Although there are clear power implications on a secure ward, if these can be addressed and explored with the client, then a psychodynamic approach could be applied. The other aspect of being able to develop a relationship that would not end prematurely, thus reinforcing Emily's feelings of abandonment, was considered thoroughly before therapy was considered. As part of

the assessment stage of Emily's admission, it was agreed by funders and our team that she would need a considerable stay (approx. 18 months to 2 years) to address her problems. There is also a thorough graded discharge that is carefully managed.

### **6.2a Attachment and the links to Learning Disability and Personality Disorder**

Bowlby (1958) and Mahler (1963) were amongst the first to study the nature of a child's attachment to their mother and noted the different stages of separation that occur at different times in the child's early life. Since these first studies, a child's attachment to their primary care giver (usually mother), in particular the stage of separation-individuation, has been seen as a crucial factor in the ego development of children (Mahler, 1965) as well as the development of object relations (Kernberg, 1972).

Research has confirmed a possible link between failing during the above stage and the development of psychopathology:

*“a general agreement exists that attachment security can serve as a protective factor against adult psychopathology .. It is associated with lower anxiety, less hostility and greater ability to regulate affect through interpersonal relatedness”* (Fonagy and Target, 2003, p. 242).

Kernberg et al., (2008) state that people with personality disorders suffer from a stable lack of integration of the concepts of self and others and that this is a consequence of the internalisation of predominantly aggressive objects over idealised objects which leads to a failure of psychological integration-to integrate the integrate good and bad self and object representations into whole object representations. Kernberg et al. (2008) go on to explain that in order to protect the idealised objects, the person's ego must remain fixated at a level of primitive dissociative and splitting defences such as projective identification, denial and primitive idealisation. It is the aim of psychodynamic therapy to support the client to reintegrate the part self-object representations into whole representations as well as promote reality testing and the development of the reality ego. By creating a therapeutic attachment relationship the goal is to repair the effects of the early disorganised attachments (Fonagy & Target, 2003). Kernberg et al. (2008) explain that when the client's split off internalised object-relations are activated in the therapeutic relationship; they can be interpreted in the transference and eventually reintegrated as whole object-representations.

It has also been observed that the early emotional and psychological processes of children with learning disabilities are also affected and that this in turn affects the nature of communication and quality of contact with primary care givers (Gaedt, 1995). Levitas and Gilson (1988) and Gaedt (2001) have found that the emotional attachments in people with learning disabilities are fragile and there is impairment or delayed development at the stages of self and object. Whittaker (2001) observed that separation-individuation is affected as a consequence of being more dependent upon others than people without learning disabilities are.

Despite the similarities, Sinason (1992) points out that there are additional defences that people with learning disabilities often employ and that need to be addressed within the therapy. Most notable is secondary handicapping, whereby disabilities are exaggerated by the client in order to gain a secret sense of victory over others. Sinason (1992) suggests that the reduction of this handicapping should be the first stage of analytic therapy, which can then lead to a second stage where the client is more vulnerable as they are having to face the depression associated with having a learning disability as well as the years lost to exaggerating their handicap. This then leads to the final stage of being able to work through this and develop an improvement in internal and external functioning (Sinason, 1992).

## **6.3 Profile of Client**

### **6.3a Personal History and Family Relationships**

Emily is a 47 year old woman of mixed white British and Eastern European origin. Her father has two children from a previous marriage. He then married her mother and had four other children, of which Emily is the second oldest. Emily describes her relationship with her mother as “not very good”, stating that they did not get on well and that she (Emily) had a lot of resentment toward her (Mother). She also said that she felt her mother saw her as difficult and a disappointment. Emily’s relationship with her father, who is now deceased, was also described as “not very good” and that he was confusing; sometimes taking her out to nice places but then beating her the next day. Her father is also reported to have drunk quite heavily and been violent towards her mother and her siblings. Emily stated that none of her siblings are close; either to her or to each other and her relationship with her youngest brother remains tense. Emily also

recalls that when she was younger she would often have “tantrums” about her siblings being normal although she is not.

Emily has also had difficulties with establishing and maintaining friendships throughout her life, she has a tendency to become over attached. There have also been difficulties with Emily’s living situation. She has lived in a number of semi supported residences as well as unsupported flats and houses since her father told her she had to leave home at age 27. Emily often ran away from these homes, back to her parent’s house, citing that she either did not like the area, the people she was living with or feeling lonely when living independently. Emily’s last home was a ground floor flat and upon moving there things deteriorated rapidly for her. It was at this time that she reported feeling unsafe and unhappy and began to present regularly at Accident and Emergency threatening suicide and self harm if she was not hospitalised. Emily also exhibited challenging behaviour towards others which escalated until she was convicted for shop lifting and being abusive to staff and police. She was then sent to a female prison for six weeks whilst awaiting assessment and subsequent admission to the specialist assessment and treatment unit where she has resided for the last nine months.

### **6.3b The Referral**

Emily’s referral to the specialist inpatient assessment and treatment unit came via the criminal justice system. At this unit, psychological therapy is seen as an integral part of the treatment process and as such Emily was seen by a Trainee Clinical Psychologist for six months. Prior to this, Emily had been seeing another Psychologist from the community learning disability team for about six months. When the Trainee Clinical Psychologist left the unit, my supervisor asked if I would be able to work with Emily. The discussions about this were lengthy as there were concerns about Emily seeing her previous Psychologist as replaceable and thus continuing her disorganised pattern of attachments. However, it was decided that if this could be broached sensitively with Emily and explored when negotiating a contract, then the benefits of seeing another Psychologist would outweigh the concerns.

### **6.3c Presenting Problem**

The referral for psychotherapy did not come directly from Emily and although she was able to state that she had a desire to talk about her problems and would like things to be different in the future, the main reason for referral to psychology from the rest of the team was to “treat” the challenging behaviour that Emily presented with both prior to and since her admission. This mode of referral is common in people with learning disabilities and a paper by the Royal College of Psychiatrists (2003) has suggested that a lack of empowerment in this population, coupled with difficulties in weighing up the pros and cons to talking about their feelings could have a bearing on this. This impacts on the power dynamics of the therapeutic relationship as previously discussed.

### **6.4 Initial Hypotheses**

I was guided by Hinshelwood’s (1991) framework for psychodynamic formulation when making my initial hypotheses. Hinshelwood (1991) suggests that by bearing in mind the object relationships that are associated with the current life situation, the infantile object-relations and the relationship with the therapist in the room, it is possible to locate the “point of maximum pain” that the client is trying to cope with. It is this pain that is associated with the object-relationship, which leads to an array of defences being employed to avoid it. In Emily’s case, it appeared that the core pain she was trying to avoid was intense feelings of abandonment. These fears of abandonment appear to be associated with her inconsistent early experiences especially those relating to her mother. Emily’s history shows a history of disorganised attachments with key figures in her life, starting with her parents. Emily talked of her mother not being there for her and how she had been made to feel like a disappointment and also reported the inconsistent and often violent nature of her father. Emily herself described these experiences as confusing and stated that she did not know how to be or what to do to make people love her. In order to evade the feelings of abandonment that this inconsistency and confusion evoked in her, she developed the defence of splitting. Throughout her life from those very early object-relationships to her current life circumstances there is a clear use of splitting people, situations and places into either good or bad. This is used in order to protect her from feelings of abandonment, which in turn evokes feelings of her worthlessness, ugliness, and being a failure and disappointment.

Emily's abandoning and inconsistent object-relationship with her mother and father was the point of maximum pain that she has been consistently living out in the way in which she has related with services, individuals involved in her care and people she has tried to make friendships with in the past. Emily has a tendency to become over attached to certain people who show her some level of affection or understanding and then demonstrates clinging and stalking behaviour. However, as would be expected of personality disordered clients (Kenrberg et al., 2008) any attempts by this person to separate from Emily, provokes a rejection reaction from Emily (either by ignoring or becoming violent toward them) that is viewed as out of context. All of these behaviours are Emily's attempt to evade the painful abandonment feelings at the core of her pain. Whilst considering Emily's early object-relationships and the defences that she employs, I was aware that they would impact on our relationship too. In particular, it was likely that I would either be seen as someone all good and perfect who she could "cling" to or someone punitive and bad who she might ignore or become violent towards-or oscillate between the two and be seen as inconsistent like her father. The therapeutic task was to explore the core pain of abandonment without getting caught up in punitive or rejecting transferences; a difficult task to say the least.

## **6.5 Negotiating the Contract and Beginning the Relationship**

As already mentioned, the contract negotiation stage was considered to be crucially important to the work with Emily. Three sessions were used to explore the idea of working with a new Psychologist and the challenges that this might bring considering that she had built a relationship with her previous Psychologist. For the first time since she has encountered mental health and learning disability services, it was decided that Emily should have the choice over whether she wanted to see another Psychologist. It was hypothesised that if Emily agreed to see me, having discussed all the potential difficulties with her and outlined the boundaries for therapy, then this would represent the best chance of establishing a therapeutic relationship that she could use effectively. The first two sessions were therefore spent exploring how she might feel that one psychologist had gone, only to be replaced by another and that it was ok for her to talk about the feelings associated with this. The commitment from her and from me were also outlined; once weekly fifty minutes sessions to take place at the same time, on the same day and in the same room each week for the duration of her admission (about 18

months). Emily was told that if for any reason she did not feel that she was able to make use of the sessions being offered to her, that it was ok to say that perhaps now was not the right time for her. The decision was then left with Emily to think about and she was told that when she was ready and had made up her mind, she could ask to see me to let me know.

It took two weeks for her to ask to see me and we met for a third time where Emily said that she would like to see me each week as she had lots that she wants to talk about, but that she wanted me to know that this did not mean that she did not miss her previous psychologist. We then set about finalising the contract details and continuing to build a therapeutic relationship. Despite this promising start, I have faced many difficulties whilst negotiating my relationship with Emily. Even though I had clearly considered the types of transferences that were likely to be present in our relationship, I often found it difficult to manage the demands placed on me by the context and the sometimes punitive transference and power dynamic that was played out when Emily's behaviour became very challenging. However, I hope that since I was able to identify this early on in our relationship and work through it with Emily in our sessions that we have been able to rebuild our therapeutic relationship as well as inform the work of other professionals working with Emily.

## **6.6 Ethics**

At the beginning of our first session together I informed Emily that I routinely tape sessions in order to reflect on my therapeutic practice, but that these recordings were absolutely confidential. I stressed to Emily that whatever decision she made would not affect her treatment in any way. I asked Emily to think about this and let me know her decision at the start of our next session, whilst reassuring her that I would not tape our sessions until she gave consent. At our next session Emily informed me that she was happy for our sessions to be taped and I asked her to read and sign the consent to tape form.

## **6.7 Aims of the Session**

The principle aim of this session was to find a way of repairing our therapeutic relationship, following the previous session where I has become caught up in the

transference dynamic and at best had become someone who did not understand her and at worst, someone who would punish her and be rejecting of her. Our previous session had left me feeling uncertain of how we could rebuild a relationship, or if Emily would even let me attempt this. It was important to me to find a way of bringing my previous mistakes into the session so that I could try and rebuild some trust as well as being able to own my mistakes to Emily, rather than “brushing them under the carpet” as others in her life had done. I hoped that Emily could then begin to build a trusting therapeutic relationship with me.

## **6.8 Lead in to the Session**

This segment is taken from our fifth session. Emily had attended a Manager’s Hearing meeting the day before where matters regarding her detention under the Mental Health Act (1983) were discussed in front of a panel and decisions were made about the continuation of the section. Emily was upset about the outcome (that she would continue to be detained) and began the session by talking about this. Our previous session had been very difficult and had resulted in me playing out a rather punitive transference dynamic. This was at the front of my mind and had considerable bearing on what I brought to the session and is why I chose this particular segment.

### **6.8a The Disc**

The transcript is taken from 1 minute and 15 seconds into the recorded session and lasts for ten minutes.

## **6.9 The Transcript and Commentary**

Emily 1: ...Lots of things came up about the shop lifting and the spell in prison, and um, about my medication, my mood swings and about things that, situations that have occurred with X, you know, which I find hard...

Cllr 1: So lots of things from the past, bringing that all up again

I was aware of feeling anxious at this point, but did not think that this anxiety belonged to me. It appeared as though Emily was talking not only about the

difficulties the Manager's Hearing had presented, but also the anxieties that meeting with me evoked in her. However, I felt that it would be premature to make an interpretation without more evidence. My intention here was to pick up on a theme of what Emily was talking about.

Emily 2: And how my mum would like to see my future, how we did used to do nice things together, went to Portugal one year together for a holiday and how my brothers were towards me before I got into all the trouble I got into. And, how she had to keep calling the police round when I was there 'cos I wouldn't let her, 'cos, um, I didn't want to go and then when she did used to take me out she had to run away from me 'cos I wouldn't let her go. And how we used to go for weekends and we'd start off alright and before I had to go back I used to say "oh I didn't want to go home..." Which, that was hard; put a lot of strain on her.

Cllr 2: I wonder if that also ties in with us as well. You say about not wanting to go, but, knowing that's difficult for you and I wonder if that relates to you and me as well. That although you want to come to the sessions, you are concerned about digging things up from the past

Emily 3: Yeah...

Cllr 3: ...and having to go through everything from the past again and whether I will just run away...

Emily 4: Yeah

Cllr 4: Whether I wont be able to cope with that either. I know that you said before you find the end of our sessions difficult too and perhaps it feels that I am just running away from everything you've just told me.

At this point (Cllr 2, 3, and 4) I was still aware of an anxious feeling located in me but was more certain now that this was Emily's anxiety that I was picking up on. It felt like Emily's anxiety was concerned with whether we would recreate a well played scenario from her past where she was left feeling very vulnerable,

punished and abandoned and that people close to her could not cope with her. I felt strongly that Emily needed me to recognise these fears of being abandoned and let down if she got close to someone and started talking about painful aspects of her past and present situation. On reflection, I think that my wording was a little cumbersome at the beginning and that my meaning might not have been immediately apparent to Emily. However, Emily's reaction (Emily 3 and 4) made me feel convinced that I had interpreted what she had said and what I had felt, appropriately. Her body language changed completely and she looked me in the eye, nodding rapidly and there was a real sense of relief from Emily that I had noticed her fears.

Emily 5: Mmmm... But everyday gets very hard in here because, unless it's a, unless it's a nurse or member of staff that's been through what you've been through they've been in your shoes, they don't, they can't understand your frustration or really what it feels like unless they've been through the same as you've been through.

Cllr 5: I think again it's like being in this room with me now, that it's quite frustrating sometimes for you that, perhaps you feel that I can't understand what you've been through and that I won't be able to, to understand it and that I will just do what other people in your life have done and just told you off.

It felt that after my interpretation in Cllr 2, 3 and 4, there was a change in the atmosphere in the room between us—a sense of relief and hope. Emily's body language changed and she appeared more engaged in the session, however, when she spoke (Emily 5), I was aware of a change in the feeling in the room once again. I felt quite alone and vulnerable, but also a little annoyed. I was fairly certain that these were not my own feelings and so I interpreted them in terms of the transference relationship between Emily and I within the therapy room. It felt as though I was representing Emily's mother, as well as all the other people from her past (other family and those involved in her care) who had not been able to understand her intense feelings and had pushed her away, punished her or dismissed her as a result. On reflection, although I feel that the essence of the interpretation is accurate, I would have tried to present the mixed feelings to Emily that I had identified, if I could do it again. I also

wanted to find a way of incorporating the fact that during our relationship, I had also got caught up in the transference dynamic and acted out a punitive role. I was not confident of including this at the time as I was unsure of how I should word this. It was still on my mind as Emily responded to my intervention (Cllr 5).

Emily 6: Yeah. Yeah. But, at the same time, there's a lot of guilt within me about what happened, the move, 'cos my mum, you know, she did spend a lot of money on um trying to make the flat nice. My sister spent time with me arranging it all to get it nice and, and my care manager said it probably didn't help those boys, group of boys, you know, constantly tormenting me, you know, used to bang on the windows in the evenings. And that went on since I moved in, the first week I was ok, you know, the first week. And they um pressed on, 'cos we had inside the flat entry, um, phone and um they pressed on that, the kids pressed on that at midnight, I knew it was kids, so I didn't answer to it, I just ignored it. And then from then the, um, tormenting and teasing steadily got worse and of course they were sitting on a wall outside, they were congregating out there at night time and, you know, talking about breaking in, so um, they were really torturing me. But one of the sad things, when the things went from the flat they also took the one, one and only pictures I had to remember of my dad, they took that. I only had one photograph to remember him by and they took it.

Cllr 6: I think that you are also talking, you might also be talking about our relationship too. That at the beginning we spent a lot of time thinking about how we were going to do things and whether you wanted to and I suppose in a similar way to what you were saying about your mum and your sister preparing the flat so that it was all nice for you, we kind of prepared our therapy together didn't we?

I felt that this was now my opportunity to incorporate the difficulties we had had in a previous session and use the communication above as well as the transference feelings to convey this to Emily. During Emily's communication (Emily 6), she kept making eye contact with me at different times. In particular,

when she was talking about her mum and sister arranging the flat to be nice but that not working out, as well as talking about the boys torturing her and messing around with and stealing her important belongings. I felt very strongly that within this communication, Emily was talking about our relationship, the hopes she had had at the beginning and her fears that I would leave her as vulnerable as she had felt in previous relationships-especially with her father. I was also aware that I felt very sad and vulnerable at this point. Although I could not help but be touched by the content of Emily's communication as well as my own regrets and concerns about our previous session, I felt confident that the sadness and vulnerability belonged to Emily and were driven by a fear that I would invade her and interfere with her memories of important people in her life. The interpretation continued into Cllr 7 and 8, each addressing different aspects of Emily's communication.

Emily 7:        Yeah

Cllr 7:            ...And tried to set it out so that it would be nice and helpful for you and since then things haven't always been too smooth have they?

Although I think that the interpretation I was making was valid, especially given Emily's response in terms of moving to a more open posture, facing me and making eye contact, as well as the same sense of relief that Emily appeared to project, there are aspects that I would change. In both Cllr 6 and 7 I end up phrasing the intervention as a question rather than a true interpretation. This not only sounds a little uncertain, but also could be interpreted as slightly patronising. This was not at all the intent and I think that Emily did not feel this way, but I am aware that this could have had a negative impact on our relationship if Emily thought I was just another person who would treat her as a child.

Emily 8:        No

Cllr 8:            ...There have been some real ups and downs and I often wonder whether you feel that I'm trying to invade you and that I'm trying to move around all those memories and all those feelings that you have and trying to

mess them, and also whether I will take away that big memory you have of your Dad and whether I will ruin that for you.

Although the intervention that I made with Emily in Cllr 6, 7 and 8 was lengthy, I felt that I needed to get across all the aspects of what she had communicated to me. I feel that a more concise interpretation might have been easier for Emily to take in, but at the time I was unable to achieve this. I think that I tried to break it down into manageable bits and that maybe the questions I used were an attempt to ensure that Emily understood, however, I acknowledge that something less cumbersome might have been better.

Emily 9: Mmmm. I did have, um, a disagreement the other day with my mum, 'cos, um, she seems to be doing a lot of activities and I was beginning to feel a bit pushed back and felt that the activities came before I did. I didn't feel that quite honestly that she was making me feel very important and that her only coming once a week waiting from one week to the next is something that is quite difficult to do. But she has said that's all she's gonna to do is come every week. You know...

Cllr 9: It seems very frustrating...

At this point I had wanted to interpret what Emily had said in Emily 9 and how the frustration feeling I was aware of, was directed at me for not being there for her whenever she wanted me as well as the envy towards me for having a "normal" life and being able to do what I want. However, Emily continued, leaving me feeling very powerless.

Emily 10: ...I'm quite envious that she can have her life how she wants it and that I have to be here, I can't have my life how I want it and when I wanted it to be good it turned so sour.

Cllr 10: It sounds a lot to me like you're talking about power and not having any power over your life. And that actually I wonder if you're talking about me too, that you don't have any power over what happens in our sessions and whether I'm here or not, how many times I come each week and that

I can leave here too, just like your mum can and just like your mum has other activities that she does, it seems that you're talking about me as well and that perhaps the other things that I do are more important than you.

The feelings of powerlessness as well as anger continued when Emily spoke (Emily 10) and they felt almost overwhelming. Upon picking them apart it seemed that they belonged to Emily. Although I had initially thought that Emily was solely talking about envy and anger, I had to modify my interpretation in light of the powerlessness that I had felt. I was aware that power and lack of it were a big issue with Emily and that throughout her life she had been disempowered, first by her mum and later by services involved in her care. I was also aware of the potential power dynamic between us too, especially considering the secure nature of the ward and the restrictions placed on her, not to mention the previous session we had where the power dynamic had become imbalanced in my favour. Upon reflection, I am not sure if I managed to address all of these things in the interpretation I made. One aspect that I would change is adding "feel" in certain places; "...you feel that you don't have any power..."; "...perhaps it feels as if the other things I do are more important...".

Emily 11: Yeah.

Cllr 12: And that I forget you when I'm not here.

Emily 12: Yeah. Yeah...

Once again, in my intervention in Cllr 12 I think that it would have been better to say "and that it feels that I forget you when I'm not here". However, I think that the meaning behind the intervention was still conveyed and that I was able to broach one of the most painful parts of Emily's feelings-that she is unimportant and forgettable and thus worthless and stupid and not deserving of being remembered or loved.

## 6.10 Discussion

Following this section of the session, Emily and I went on to talk more about her relationships with her mother, sister and brothers, as well as touching on the clearly painful memory of her father. Throughout the session I continued to work within the transference, interpreting what Emily said as communications about our relationship. Later in the session, Emily and I were also able to explore the loss that she still felt about her previous therapist and make associations with her core pain of abandonment. But, perhaps most importantly of all, by the latter part of the session Emily was able to openly acknowledge how rejected she had felt after our last session together. Although this session was by no means perfect, I feel that it did go some way to start to rebuild the therapeutic relationship that had been damaged by the previous weeks' session. Despite this, I know that Emily and I have a long way to go and that it will take more than just one session to fully build a trusting, therapeutic relationship. Indeed, since this session we have seen each other weekly for about 8 months. In many of the sessions that followed Emily and I were still negotiating many of the issues brought up by some of my errors of playing out painful punitive projective identifications in that early session. However, this is occurring less and less as we acknowledge and explore them together within the transference. I have noticed that as it appears that we are building up some trust, Emily is able to talk more about some of the more painful experiences in her life, in particular those that were hinted at in this segment regarding her father.

One other crucially important factor to note, is that since this and subsequent sessions, I have noticed that Emily is using more of her adult self, both in terms of content and the voice in which she speaks, within our sessions and when communicating with other staff and peers. Although these are positive signs, I am by no means suggesting that this is because I have become the perfect therapist. Even in the segment above, there are times when my interpretations are cumbersome and lengthy and might not fully interpret all aspects of Emily's communication. I have found that supervision has been essential in my work with Emily as it has allowed me to work through my mistakes and support me in working within the transference to hear the unconscious communications that Emily is making. It has been especially helpful at supporting me to fine tune my interpretations so that they are more concise but yet fully interpreting the communication. At the same time, I am aware that my learning has had a profound impact on the rest of the professionals who work with Emily-we have established ways

of communicating with Emily at times of distress that do not reactivate her feelings of abandonment by replaying punitive or rejecting transference dynamics.

Although I have already offered a critique of some of the technical aspects of the application of the psychodynamic model in the transcript and commentary section, it is important to devote some time to discussing this further. The interpretations that I made in the above segment all used the transference relationship and were very much focused on understanding what Emily was talking about in light of our relationship. Although at the time it felt important to use the relationship to understand what Emily was trying to tell me, it is possible that by doing this some other aspects of unconscious communication were missed or left incompletely interpreted. I have reflected on this at some length and have wondered whether this was the “right” thing to do. What I have concluded is that there may have been some times when I could have extended the interpretation to include aspects other than the immediate relationship between us in the room. However, I felt keenly that bridges must be built and our therapeutic relationship re-established in order for us to stand any chance of working together in the future. Interpreting in the light of our relationship seemed the most appropriate way to do this at the time. It is also important to remember that this segment is taken from the opening part of our session and that there are times later in the session that other types of interpretation are made that do not refer directly to our relationship.

As I have already mentioned, Emily and I have worked hard at repairing our relationship and by being able to openly acknowledge that I am not perfect and have not always got things right has been incredibly useful in our therapy together. Although it happened earlier in our relationship than I would have liked and although it was through me getting drawn into enacting a projective identification, Emily and I have been able to tackle issues associated with ambivalence and being able to see me as “good enough” but not perfect or terrible. This is something that Emily has had considerable trouble with in her past relationships and people have been split into good or bad. Emily and I have worked incredibly hard at reaching a point where she is able to accept that although we did not start out well together, there are actually many good aspects to our relationship too. This has also become evident in her relationships with some of her family and some of the other clients on the ward.

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## **Section 3: Critical Literature Review**

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### **7.0 Can Attachment Theory Provide an Explanation for the Challenging Behaviours Exhibited by Some People with Learning Disabilities?**

#### **7.1 Introduction**

Various attempts have been made over the years to establish exactly what percentage of people with learning disabilities display some form of challenging behaviour. Figures quoted have ranged from 7% (Emmerson, 2001) to 87% (Einfeld & Tonge, 1996a). It is likely that the use of different definitions of both learning disability and challenging behaviour across different studies along with the use of unstandardised assessment tools could explain this huge range (Wallender, Dekker, & Koot, 2006). Recent research using clear definitions of the above terms as well as standardised assessment tools have at least been able to reduce this range and most figures now suggest a range of between 35% and 49% (Wallender et al., 2006). It is not surprising, though, that it has been difficult to reach a satisfactory definition of either term as there are so many conflicting opinions of what constitutes either a learning disability or a challenging behaviour. Even the terms themselves are not set in stone and vary immensely from country to country (for the purpose of this review the terms intellectual disability, mental retardation and learning disability will be used interchangeably). Despite a lack of agreement over the precise terminology, a consensus has been reached among professionals with regards to the core features that constitute a learning disability; there must be significant impairment of intellectual and adaptive/social functioning and onset must occur before adulthood (Ball, Bush, Alick, & Emerson, 2004). This definition appears to be more of a set of diagnostic criteria than a definitive explanation of what a learning disability is, however, due to the heterogeneity of people that make up this group, it is all that can be agreed upon at this time (Ball et al., 2004).

Challenging behaviour is another term that has suffered from a lack of clarity and consensus among professionals and attempts at explanation have mainly been service led and have often raised more questions about these services than they answer (Ball et al., 2004). The most commonly used definition is:

*“Severely challenging behaviour refers to behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities.” Emerson, Cummings, Barrett, Hughes, McCool, and Toogood, (1988).*

This definition does at least feel a little more complete than that of learning disability; however, it might not take into account some of the less severe behaviours that nonetheless present serious challenges to the individual and their families.

Even if we were to apply these definitions without analysing their validity, the question would still remain of why some people with learning disabilities display challenging behaviours and others do not. It is generally accepted that the more severe and profound the learning disability, the higher the prevalence of challenging behaviour (Janssen, Schuengel, & Stolk, 2002). Yet this cannot be considered a complete answer to such a complex question as it neither addresses why the difference in severity of learning disability results in an increase in challenging behaviour, nor, why people with only mild to moderate learning disabilities still exhibit challenging behaviours (albeit, to a lesser extent). Indeed, research is beginning to move towards a developmental explanation of challenging behaviours in people with learning disabilities, in particular, examining the role that early attachment plays in the subsequent development of such behaviours (Janssen et al., 2002).

Some studies have suggested that challenging behaviour remains remarkably resistant to change over time. In a 26 year follow up, Thompson and Reid (2002) suggested that challenging behaviours were persistent over this period of time. However, a further examination of the data used to substantiate this claim, shows that there are considerable methodological limitations. One such limitation is that during this 26 year period, there have been huge improvements in the way in which such behaviours are measured and as such, it is possible that more recent figures show an increased ability to capture and record this data rather than reflecting a real difference in the number and types of challenging behaviours recorded in earlier stages of the study. Another important note of caution must also be urged when looking at the data as a whole rather than looking at the change in each participant. The percentages and numbers would suggest that challenging behaviour has remained stable over time. For example, there

are near perfect correlations when looking at sleep disturbances, but, although the same number of people had sleep disturbance at time one and time two, they are not the same individuals. It is also unclear from this study, whether any attempt was made by the homes or hospitals to provide any training to staff on working with people with challenging behaviours and implementing any kind of strategies to reduce them.

There is a considerable amount of evidence that points to the effectiveness of behavioural interventions for reducing challenging behaviours in people with learning disabilities (e.g. Sturney, 2005). Yet, it has been suggested that there are a subset of people with learning disabilities for whom behavioural modification strategies alone, appear to have limited effect on reduction of challenging behaviour, such as those who appear insensitive to social contingencies to their behaviour or have had pathogenic parenting (O'Reilly, Murray, Lancioni, Sigafoos & Lacey, 2003). Sterkenburg, Janssen and Schuengel (2008) found that for children with severe intellectual and visual disabilities an attachment based behaviour modification therapy was more effective at modifying challenging behaviour than behaviour modification strategies alone. This raises a number of important questions such as; exactly how interventions based on using attachment theory might differ from any other intervention that might be applied to modify or reduce challenging behaviour and who is more likely to be helped by a behaviour modification therapy that incorporates an attachment phase? Before attempting to answer these questions, a thorough examination of attachment theory; its origins, relationship with psychopathology, learning disability and syndrome specificity, is offered.

## **7.2 An Overview of Attachment Theory**

In order to fully consider the extent to which attachment theory could further our understanding and conceptualisation of the development of challenging behaviours in some clients with learning disabilities, it is essential to have a good grasp of this complex concept. It has long been observed that infants develop strong ties to their mothers and up until the 1950s it was widely accepted that this was due to the fact that the mother feeds the infant, which gives rise to an association within the infant that the mother's presence is linked to the positive feeling of having hunger drives satisfied (Freud, 1957; Sears, Maccoby, & Levin, 1957). This explanation was known as a secondary-drive theory (Freud, 1957; Sears et al., 1957). However, this theory could

not offer a satisfactory explanation of the emerging results of groundbreaking animal studies. One of the most influential of these studies was conducted by Harlow (1958) who observed that in times of stress, when faced with the choice of the wire-mesh “mother” that provided food and the cloth “mother” who could merely provide contact comfort; young rhesus monkeys almost always opted for the cloth “mother”. Ainsworth (1967) amongst others (e.g., Schaffer & Emerson, 1964) soon began to observe that human infants were also able to become attached to people even if they did not feed them.

These observations prompted Bowlby (1969) to suggest that underlying the infant’s tie to its mother was a biologically based need for proximity, driven by evolutionary pressures. He proposed the concept of an attachment behavioural system which involves the notion of innate motivation (Bowlby, 1969). This concept would suggest that infants should become attached to their mothers regardless of whether they are meeting their physiological needs (Cassidy, 1999). Bowlby (1969) found that when mothers were abusive towards their babies, these infants still became attached to her which would appear to strengthen the notion that pleasurable associations were not driving this system. Bowlby (1969) described this as a regulatory system which seeks to maintain a desired distance from the mother (dependent on context) and therefore maintain a certain emotional state within the child.

Bowlby (1969) stressed the role of context, emotion and cognition. Context can drive the degree of proximity desired by the child and can be influenced by factors relating to the condition of the child or condition of the environment (Bowlby, 1969). Emotion arises from the various stages of attachment; formation, maintenance, disruption, renewal and loss and Bowlby (1969) suggested that a child predisposed to positive affect may work harder at maintaining attachments and thus enhance reproductive fitness. Cognition was also said to be necessary as mental representations of the attachment figure, environment and the self are required (Bowlby, 1969). These representations are said to be key to choosing which attachment behaviours to use with which individual and need to be constantly checked and updated via conscious processing and accurate reflections of reality (Cassidy, 1999).

The theory of attachment does not stop at the concept of a socio-emotional regulatory system; it goes further and looks at this system in relation to others, in particular the

exploratory system. Ainsworth (1972) proposed that maintaining a balance between these two systems was more important for development than either one on its own. The idea of the infant using the attachment figure as a “secure base from which to explore” is perhaps the best known framework that links these two systems (Ainsworth, 1972). The infant maintains a balance between these two systems by assessing the caregiver’s availability and the characteristics of the environment before responding (exploring/playing or not) (Ainsworth, 1972). When the environment is dangerous or the attachment system is activated then exploration and play is unlikely, however, when the attachment system is deactivated, the opposite has been found to be true (Ainsworth, 1972). Bowlby (1973) went on to stress the importance of the perceived availability of the caregiver rather than the mere physical presence, in determining how the infant will respond and whether exploration will increase or decrease.

This perceived availability of the attachment figure was also important in another aspect of the theory of attachment; that of the attachment bond. The extent to which an attachment can be considered secure or insecure can be located in the attachment bond (Ainsworth, 1989). One of the criteria that must be fulfilled in establishing an attachment bond is whether the individual seeks comfort and security in the relationship or not (Ainsworth, 1989). If security is found in this relationship then the quality of the attachment is considered to be secure, if, however, this is not achieved, then the quality of the attachment is considered to be insecure (Ainsworth, 1989). The quality of the infant attachment was found to be critical in the development of the capacity to cope with stress and generate and maintain states of emotional security (Ainsworth, 1989).

### **7.3 The Strange Situation**

In order to measure these qualities of attachment, Mary Ainsworth and colleagues (1978) developed the “strange situation” assessment tool that is intended to be a mild to moderately stressful experience for the infant. In this laboratory procedure, the parent and infant are introduced to a room. The infant settles and begins to explore for three minutes. A stranger is then introduced to the room with the parent and infant and the stranger then plays with the infant for a further three minutes. The parent then leaves the infant alone with the stranger for another three minutes before returning to the room. At this time the stranger leaves quietly and the infant and parent are reunited for three minutes. After this, the parent leaves the infant alone in the room for a further three

minutes. At the end of this time, the stranger re-enters the room and stays with the child for three minutes. The final episode of the procedure sees the infant and parent reunited for a second time for a duration of three minutes (the stranger exits the room quietly) (Ainsworth, Blehar, Waters, & Wall, 1978).

On the basis of parent-infant interaction at the two reunion episodes, Ainsworth et al. (1978) proposed that the infant's behaviour toward the parent could be classified into one of three main groups of organised attachment quality; one secure group (B) and two insecure groups (A) avoidant and (C) ambivalent. The parent-infant interaction was categorised using four scales; proximity seeking, contact seeking, avoidance and resistance to contact and interaction. The main characteristics of (B) secure infants were; they used mother as secure base for exploration, missed parent during separation but upon reunion greeted parent with smiles or gestures, sought contact with parent if upset but once comforted continued to explore (Ainsworth et al., 1978). (A), avoidant children, explored readily but showed no signs of secure base behaviour, showed little visible distress on separation and actively avoided parent upon reunion (Ainsworth et al., 1978). Ambivalent children, (C) were visibly distressed on entering room and showed no signs of exploration. They were unsettled during separation but became either angry and rejecting or passive and too upset to signal upon reunion. They also failed to find comfort in the parent (Ainsworth et al., 1978).

However, although these classifications were useful at separating out securely attached children from insecurely attached children, researchers were finding that approximately 15 % of attachments in normative samples were difficult to classify using the original A, B, C criteria (Main & Solomon, 1986). This led to the development of guidelines for a fourth group that was called disorganised/disoriented (D) (Main & Solomon, 1990). The main characteristics of infants in this group was a lack of observable goal, intention or explanation, e.g., stereotypies; freezing/stilling; incomplete/interrupted movement. These children also showed fear or apprehension of parent and lacked a coherent attachment strategy, despite possibly showing signs of an underlying organised, A, B, C, pattern of attachment (Main & Solomon, 1990). Ainsworth et al. (1978) reported on the home behaviours of a small set of the original strange situation sample and found that infants who would later be classified as securely attached cried less at home and were more compliant and showed less overt anger than children who would later be classified as insecurely attached. The mothers of children who would be later classified

as securely attached were more sensitive in interaction, less interfering of the child's behaviour and more accessible to the child than mothers of children who would later be classified as insecurely attached (Ainsworth et al., 1978). Although many others have replicated these core findings (Bates, Maslin, & Frankel, 1985; Grossmann, Grossmann, Spangler, Suess, & Unzer, 1985; Isabella, 1993), there have been few reported observations of mother-infant interaction in the (D) category. Despite this, Main & Solomon's (1990) criteria strongly suggest a dysfunctional mother-infant interaction, such as maltreatment or a mother who experiences dissociative states, which would invoke fear in the child (Van Ijzendoorn, Schuengel, & Bakermans-Krenenburg, 1999).

The validity of the strange situation assessment tool has been tested and it has been found to be a reliable and valid test of infant-parent attachment style, with an intercoder agreement ranging from 100% in the original Ainsworth & Bell study (Ainsworth et al., 1978) to 85-95% for researchers who were trained by Ainsworth and colleagues (Main & Weston, 1981). However, criticisms have been made about its ecological validity and its validity based on age of the child (Waters & Deane, 1985). An alternative attachment assessment tool that attempts to remedy these shortcomings, the AQS (The Attachment Q-Set) can be used for a wider range of age groups and is based on observations within the child's own home (Waters, Merrick, Albersheim, & Treboux, 1995). Yet, despite being ecologically and age-range valid, the AQS does not offer an attachment classification; it can only yield a continuous score representative of attachment security (Howes, 1999). Throughout studies of attachment the strange situation has been the assessment tool traditionally used and has contributed to our understanding of attachment styles and the short, mid and long-term effects associated with each of these. However, its use with children with learning disabilities, in particular Autistic Spectrum Disorder, has been mainly overlooked as it has been presumed that such children are incapable of making an attachment to the parent (Willemsen-Swinkels, Bakermans-Kranenberg, Van Ijzendoorn, Buitelaar, & Van Engeland, 2000).

#### **7.4 Effects of Early Attachment Styles in People without Learning Disability**

Bowlby (1944) began his work on attachment after his observations at a home for maladjusted boys convinced him that the mother-child relationship was crucial to later

functioning and that disruptions in the relationship were precursors to later psychopathology. Most of this early work was carried out through retrospective examination of existing literature (Bowlby, 1944, Bender & Yarnell, 1941), but as the theory of attachment progressed along with the tools needed to measure this concept (strange situation, Ainsworth et al., 1978), so too did the ability to establish the immediate and longer term impact of secure and insecure (including disorganised) attachment styles.

Studies into the effects of attachment style on later adaptation have focused on the following areas; dependency, self reliance and efficacy; anxiety, anger and empathy; and social competence (Weinfield, Sroufe, Egeland, & Carlson, 1999). Time after time, the research, spanning over 30 years, has found that early attachment history contributes to a child's developing effectiveness in the world (Weinfield et al., 1999). One such piece of research that has contributed our understanding of the effects of attachment histories is the Minnesota Parent-Child Project (Sroufe, Fox, & Pancake, 1983). This longitudinal study of middle-class families (along with other longitudinal studies of attachment) has found that children with secure attachment histories believe that they can get their needs met via their own bidding, acquire a strong empathic foundation from their early attachments and are able to regulate their affect in response to their own and other's states of distress (Weinfield et al., 1999). With regards to social competence, research (Sroufe & Fleeson, 1988) has shown that secure attached infants expect social partners to be responsive to them and in turn that they are worthy of these positive responses. Some studies have also found that people with securely attached histories are more effective in a mixed sex group, are more competent in general (Sroufe et al., 1983) and showed greater leadership abilities during group problem solving situations (Englund, Levy, & Hyson, 1997).

These studies appear to show an advantage for children and adults with secure attachment histories, however, they do not necessarily imply that those with insecure (avoidant, ambivalent and disorganised/disoriented) attachment histories are at a disadvantage. According to Bowlby's (1969) theory of attachment, people with insecure attachment histories should be at greater risk of exhibiting problems in the areas of; dependency, self reliance and efficacy; anxiety, anger and empathy; and social competence (Weinfield et al., 1999). Indeed, from the great abundance of research carried out to test these constructs, it would appear that children with insecure

attachment histories are at a disadvantage to their securely attached counterparts (Weinfield, et al., 1999). However, it has been found that there isn't just a split between the secure and insecure attachment styles, but that the three different insecure styles can also predict diverse outcomes of the above constructs (Weinfield et al., 1999). Cassidy & Berlin (1994) established that ambivalent attachment histories predicted anxiety problems in later life, as a consequence of the constant vigilance developed in their early relationships. Suess, Grossman, & Sroufe, (1992) found that children with avoidant attachment histories exhibited increased hostility and scapegoating of peers which was consistent with the findings of Sroufe (1988) who observed that children with avoidant histories were more likely to victimize their partners in the task and ambivalent children were more likely to become victims than the securely attached children who were neither shown to become victims nor to victimise.

In terms of the development of child and adult psychopathology, attachment style has been found to play a role (Sroufe, 1997). It has been shown that those with ambivalent attachment histories were found to be more likely to suffer from anxiety disorders (Warren, Huston, Egeland, & Sroufe, 1997), possibly due to a low tolerance of frustration (Weinfield et al., 1999). Early ambivalent attachment did not predict any forms of externalising behaviour; however, it has been proposed that people with avoidant histories were more vulnerable to suffer from conduct problems and some personality disorders, possibly due to the lack of empathy, alienation and hostile anger of those with such histories (Weinfield et al., 1999). It has also been suggested that although both types of insecurely attached people are more vulnerable to suffering from depression, the reasons underlying it might be strikingly diverse; ambivalent attachment might lead to passivity and helplessness whilst avoidant attachment might lead to alienation and aloneness (Weinfield et al., 1999).

It is also interesting to note that research into attachment style and effects on later adaptation have not stopped at observations of behaviour, they have also looked at the physiological and biological consequences of early patterns of attachment. Schore (2001) found that children who showed secure patterns of attachment have a significant effect on right brain development. In line with Bowlby's (1969) idea that secure attachment has evolutionary advantages and is part of an attachment system, Schore (2001) has proposed that increased right brain development has a positive impact on the human response for stress and thus facilitates the child's coping capacities. This

biological model also fits with the findings on physiological stress responses in disorganised attachments, which are discussed in the next section. The findings associated with the third category of insecure attachment, disorganised/disoriented, are vast and due to this will be discussed in further detail below.

Counselling Psychologists see clients with just such problems as mentioned above, everyday, and although each individual should be seen as unique in their experience and feelings, it might be useful to bear in mind this attachment perspective (in particular looking at the importance of early relationships) when assessing and treating clients. Whether that treatment is being offered at the level of the individual in terms of one to one therapy or by supporting family and carers to understand and modify challenging behaviour. However, as we are reminded by Sroufe (1997), attachment style does not account for all the variance in clients presenting with psychopathology and that although it is still regarded as a highly significant predictor, it cannot be looked at in isolation and can be mediated by a number of other factors. A secure attachment history does not guarantee mental health, it is merely a protective factor, and insecure attachment does not mean the eventual development of psychopathology, it should instead be seen as one of a number of risk factors (Sroufe, 1997).

## **7.5 Disorganised/Disoriented Attachment**

Perhaps the most abundant source of information on the effects of attachment style on later adaptation has come from the studies of people with disorganised/disoriented attachment histories. Following a meta-analysis of nearly 80 studies looking at disorganised attachment in early childhood, Van Ijzendoorn, Schuengel, & Bakermans-Krenenburg, (1999) concluded that this style of attachment was critical in the development of child psychopathology and externalising behaviours. The reason for this has been put forward by Carlson (1998) who reported that the increased risk of externalising and dissociative behaviour in later life of infants with disorganised attachment styles could be established in terms of problematic stress management. This explanation has received support from earlier psychophysiological research which has shown that disorganised attached children show more physiological stress during and shortly after the strange situation compared to children with organised attachments (A,B,C attachment styles) (Spangler & Grossmann, 1993). Although it could be said that the strange situation task is designed to be stressful and so stress levels themselves

might not necessarily be an indicator of attachment style, the findings show that infants categorised as disorganised consistently show higher stress levels than that of organised children (Spangler & Grossmann, 1993).

In clinical groups and groups of poorer social context, the rate of disorganised attachment has been found to be as high as 45%, compared to 15% in middle class families (Van Ijzendoorn, et al., 1999). This high rate in these groups begs the question to be asked as to why this difference exists, however, as yet research into this area is limited and explanations as to the cause of disorganised attachments are few. Hesse & Main (1999) have proposed the idea that frightening or frightened as well as dissociated parental behaviour play an important role in the development of disorganised attachments. Yet, they also found that these seemed not to be the only causal factors involved (Hesse & Main, 1999). It would appear that in order to prevent or treat the disorganised attachment style, a comprehensive account as to why it develops in the first place would be of huge importance. Therefore, future research into this area could provide us with invaluable insights into this most unknown of all the attachment styles as well as possible implications for the implementation of treatment strategies for Counselling Psychologists to consider.

## **7.6 Attachment in People with Learning Disability**

Bearing in mind the cognitive constructs that Bowlby (1969) believed to play a crucial role in the development of an attachment system, it could be proposed that children with learning disabilities might lack the cognitive functioning required to not only model, but constantly check and update representations of the attachment figure, the self and the environment. Indeed, as mentioned previously, it was long assumed that children with learning disabilities, in particular those with Autistic Spectrum Disorder, were incapable of forming attachment relationships (Willemsen-Swinkels et al., 2000). Yet, it would appear, from looking at the effect of attachment style on later adaptation in people without learning disability, that if attachment were found to be possible in people with intellectual disabilities then challenging behaviour could start to be assessed as a consequence of attachment style rather than as a consequence of learning disability, per se.

Research into the risk factors for psychopathology (including challenging behaviour) in children with learning disabilities has repeatedly found that family functioning is critical to the later adaptation of the child (Wallender et al., 2006). Wallender et al. (2006) have also suggested that targeting family functioning would be an important strategy in reducing the onset of psychopathology in these individuals. Other studies looking at parenting stress in mothers of children with intellectual disability have shown that children who exhibit more behaviour difficulties have mothers with higher parenting stress who tend to have a more external locus of parenting control (Hassall, Rose, & McDonald, 2005). Although neither of these pieces of research has directly looked at the effect of attachment style on challenging behaviour, it could be argued that family function could be related to attachment. Therefore it could be hypothesised that securely attached child-parent relationships would be predicted to be part of a better functioning family dynamic and therefore be at less risk of developing psychopathologies (Bowlby, 1973). Again, a parent who displays more stress and might be considered by the child to be frightening or unavailable could be at greater risk of an insecure attachment pattern developing, which could thus account for the more challenging behaviours presented by this group.

So far the evidence presented has only suggested a possible direction for future research and implied a promising link between attachment style and the development of challenging behaviours. In 2000, Willemsen-Swinkels et al. looked at insecure and disorganised attachment in children with Pervasive Development Disorders (PDD, such as Autism) and they found that children with PDD are able to develop secure attachments to their primary caregiver at similar rates to children without PDD and non-clinical samples. However, they also found that children with a dual diagnosis of PDD and mental retardation were more often classified as disorganised than “normal” controls or children with PDD (Willemsen-Swinkels et al., 2000). This result is consistent with the finding that people with learning disabilities exhibit more challenging behaviours than people without intellectual impairment (Janssen et al., 2002). Bearing in mind these two findings, it could be suggested that there is a link between attachment style and development of challenging behaviour.

However at this stage one can only surmise as to why this might be and it is possible that the stress of having a child diagnosed with a learning disability might adversely affect the attachment relationship in some parents. While the parent is processing this

new information they might not be as available to their child or might even be at greater risk of dissociating from the child and thus the relationship would be at increased risk of being insecure or disorganised. Further research into answering this question would prove useful for the future as insight into the causes of these styles of attachment would prove invaluable for both prevention and treatment of challenging behaviours in this client group. Despite a distinct lack of research in this area, a stress-attachment model of challenging behaviours in people with intellectual disability has been proposed by Janssen et al. (2002). This links the finding that people with intellectual disability are at greater risk of developing disorganised attachments (Willemsen-Swinkels et al., 2000) with evidence that a combination of stress and insecure attachment puts people at increased risk of developing behaviour problems (Carlson, 1998). This model has received support from Clegg & Sheard (2002) who found that insecurely attached children with intellectual disability showed greater behavioural problems than children who were securely attached.

Despite the fact that this looks like a promising model of challenging behaviour in people with learning disability, it is important to recognise that, as with attachment effects in people without learning disability, insecure attachment style can only be seen as risk factor or predictor of future psychopathology (Sroufe, 1997) and is therefore not the only possible predictor. One other important factor to consider is whether attachment in people with a diagnosis of Autism and a learning disability happens either in a different way or at a later stage. It is important to remember that Willemsen-Swinkels et al. (2000) found that people with a diagnosis of Autism were still able to make secure attachments, but that it was the additional diagnosis of a learning disability that added to the risk of becoming insecurely attached. Further research is necessary to establish whether the stress of having a diagnosis of Autism and of a learning disability is really significantly higher than having just one diagnosis or the other, before it is possible to suggest a stress attachment model as a means of accounting for problems of attachment and challenging behaviour.

However, if a stress-attachment model of challenging behaviour in people with learning disability could be further supported then the implications for both prevention and treatment, as Counselling Psychologists, would be vast. A family systems approach could be adapted to the prevention of developing insecure and disorganised attachments, which could work at establishing an attachment bond between the infant-caregiver,

whilst trying to remedy the problems that caused the attachment style problems in the first place. In terms of treatment, specific frameworks have already been used to treat individuals with sex offending histories (Rich, 2005) and could be adapted for the treatment of challenging behaviours in people with learning disabilities.

## **7.7 Syndrome Specificity and Challenging Behaviour**

In line with the finding of Willemsen-Swinkels et al. (2000) that children with a dual diagnosis of Autism or other PDDs and a learning disability, are at greater risk of developing insecure, disorganised attachments, recent research has started to look at the affect of syndrome specificity on behaviour and maternal well-being (Eisenhower, Backer, & Blacher, 2005; Blacher & McIntyre, 2006). Although neither of these studies directly address the concept of attachment patterns as related to challenging behaviour, it is possible that by reviewing their findings and looking at them with an attachment model in mind, it might offer up possibilities for research that could further our understanding of this complex construct.

With recent advances in the decoding of the human genome, it is now possible to start looking at the behavioural phenotypes of the various known specific syndromes associated with learning disabilities (Blacher, 2003). The Down syndrome “advantage” (Seltzer, Krauss & Tsunematsu, 1993) has been recognised for almost 15 years and refers to the distinct lack of maladaptive behaviours in this syndrome that appears to lead to families experiencing more cohesiveness, less stress and less care-giving burden. In stark contrast to this, the families of children with autism frequently report greater stress and negative impact (Blacher & McIntyre, 2006). Blacher & McIntyre (2006) found that the highest levels of behavioural problems were found in the group with Autism, whilst the lowest were found in the group with Down syndrome. They also noted that maternal well-being scores were directly related to diagnostic group and was almost entirely accounted for by the level of behaviour problems, with mothers of children with Autism reporting less well-being and mothers with children with Down syndrome, higher levels of maternal well-being (Blacher & McIntyre, 2006). Although, it is crucial to consider other factors that might be associated with this difference in levels of well-being between the two groups of parents. Further research that took into account and questioned other areas, such as the level of social desirability associated with each syndrome as well as the uncertain prognosis and unpredictability associated with a

diagnosis of ASD, might offer further insight into the differences found by Blacher and McIntyre (2006).

However, if we were to look at these findings from an attachment point of view, it might be possible to suggest that maternal stress might impact on the availability of the primary care-giver and thus increase the chances of an insecure attachment being formed in children with Autism (as found by Willemsen-Swinkels et al., 2000), which in turn would be a risk factor for future challenging behaviour. It could also be hypothesised that the lower levels of behaviour problems in children with Down syndrome were as a consequence of being more likely to make a secure attachment. However, at this stage, this hypothesis is merely conjecture and this research would need to be replicated with an additional attachment categorisation element, before any credence could be given to it. A longitudinal study would also be of benefit as it could hopefully provide further evidence of a causal nature that could either support or refute the idea of a stress-attachment model of challenging behaviour (Janssen et al., 2002). As noted above, other factors might also be associated with increased parenting stress and lower levels of well-being (such as social desirability, uncertain prognosis, difficulty surrounding diagnosis, etc.). Further research would be necessary to establish how these impact on parents and their subsequent well-being and if they are associated with the type of attachment the child and parent are able to make.

## **7.8 Summary and Conclusions**

Having established the precise nature of the attachment relationship and examined effects associated with secure and insecure attachment styles on later adaptation, it has been possible to start to consider why such a world renowned, accepted theory of attachment has not been deemed possible to apply to people with learning disabilities. It would appear that presumptions made about the inability of children with learning disabilities to become attached to primary care-givers (Willemsen-Swinkels et al., 2000) have hindered the exploration of this construct in relation to this client group. Through looking at the research on attachment in learning disabled, non learning disabled and clinical groups, it has been possible to establish that an early attachment quality could be a predictor of later adaptation (Sroufe, 1997). In particular it has become apparent that people classified as having a disorganised attachment history are more likely to exhibit externalising, aggressive behaviour than people with any other attachment

history (Van Ijzendoorn et al., 1999) and that this could be due to problematic stress management capabilities (Carlson, 1998). With this in mind, Janssen et al. (2002) proposed a stress-attachment model of challenging behaviour to try and account for the large number of people with learning disabilities who had disorganised attachment histories.

Having reviewed the literature it is now possible to attempt to explain why the more severe and profound the learning disability the higher the prevalence of challenging behaviour (Janssen et al., 2002), by using an attachment theory perspective. It is possible that the more severely learning disabled a child is, the less cognitively he or she will be developed, which in turn could affect their ability to accurately represent themselves, the environment and the primary care-giver (Bowlby, 1969) and thus render the possibility of a secure attachment more difficult. It could also be suggested that the age at which the learning disability begins to seriously impact on cognitive development could also influence the level at which the cognitive modelling is able to occur and thus account for difficulties in establishing secure attachments (Bowlby, 1969).

Although the stress-attachment model (Janssen et al., 2002) could prove to be useful in trying to explain the challenging behaviours in some people with learning disabilities, it must also be stressed that as attachment history does not account for 100% of psychopathological outcomes, it should by no means be seen as a definitive answer. Having said this, it could prove to be a vital tool in assessing those with learning disabilities who are most at risk of psychopathological outcomes (including challenging behaviour) and enabling family or mother-infant intervention strategies to assist in the development of an organised attachment pattern and thus reduce the chance of later behaviour problems. This would provide a preventative strategy for people with learning disabilities; however, an attachment model of challenging behaviour could also assist in the delivery of treatments, by Counselling Psychologists, following an attachment framework which would seek to address the attachment history and thus treat the potential cause of the behaviour rather than just the behaviour itself. Either by way of working in a one to one talking therapy with those who could benefit from such an intervention, or by supporting carers, family and others working closely with the individual to be able create a “safe base”. Through this “safe base” affect regulation could be improved (Bowlby, 1983) allowing for an increased sensitivity to social

reinforcement (O'Reilly et al., 2003). This would hopefully lead to better outcomes for those people with learning disabilities presenting with challenging behaviours.

When referring back to the introduction of this review, questions were raised about how behaviour modification strategies that incorporated an attachment phase were different to other strategies and who such interventions would be most beneficial for. It has been highlighted throughout this paper that our understanding of attachment and the role it plays in the development of psychopathology and challenging behaviour is growing. However, it has also been shown that, although an important factor in healthy development, an insecure or disorganised attachment is only one of a series of risk factors and cannot account for 100% of either psychopathology or challenging behaviour. Having this understanding that attachment or a lack thereof could be a risk factor, increases the way in which the complex phenomena of challenging behaviour can be understood. This appears to hold especially true for those people who have experienced the most pathogenic parenting and where an insensitivity to social contingencies to their behaviour has made shaping using social reinforcers difficult and less effective than those who are more sensitive to social contingencies (O'Reilly, et al., 2003). The work by Sterkenburg et al. (2008) appears to support this notion.

One other possibility is that these findings reflect a difference in interpretation of what is meant by behaviourism, based on very early and narrow understandings of this model, rather than reflecting a fundamental difference in the way in which a modern applied behaviourist would intervene or think about challenging behaviours. Clements (1991) sums this up well when he suggests that one reason applied behavioural techniques are not always carried out is that they are identified with what have been described as “cold, mechanistic and non-humanistic” interventions. It would seem plausible to suggest that both modern applied behaviourism and modern attachment theory might have more commonalities than differences, representing different languages and ways of describing the same phenomena rather than coming from fundamentally opposing ends of the theoretical spectrum. It would appear that applied behavioural interventions, such as active support, recognise the huge importance placed on building a relationship with clients as well as an understanding of the function of challenging behaviour in the here and now, in addition to how this behaviour has developed over time. However, as many researchers have suggested, the way in which behavioural strategies are carried out by families, staff and carers could affect the

outcome of its effectiveness (Clements, 1991; Mansell, Elliott, Beadle-Brown, Ashman, & Macdonald, 2002) . If they are seen as things to be done to people in a mechanistic way, rather than as a strategy to be applied alongside a positive attachment relationship (be that a loving, familial relationship or a positive therapeutic relationship) they are potentially less likely to be effective.

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Interview Schedule

- What is it like to work at MIETS/Can you tell me about working at MIETS?

**Prompts:**

What is your role?

What kind of unit is this-patient type?

Who works here-MDT?

- I would like to talk a bit about “patient engagement” on the unit; can you tell me what that term means to you?

**Prompts:**

What is it?

Who does it?

How important is it?

A question looking at how engagement emerges, how do participants actions construct engagement. What specific act comprise this activity (does it mean the same to everyone)

From whose point of view is engagement fundamental. From whose point of view is it marginal

Who exerts control over the process and under what conditions

Participants feelings around this issue,?

- Do you feel that anything impacts upon how you engage with patients on this ward?

**Prompts:****What helps, what doesn't help**

How is communication-inter and intra discipline?

What is support like-management and inter/intra disciplinary?

What impact does a patient's mental state have?

Is there an understanding of the needs of this client group?

Do you think that political pressures (funding-both staff and patient, changes in policies, the need for so much documentation about everything associated with patient care) affect your ability to engage patients?

What about the design of the unit?

- What happens when decisions need to be made about the care of a patient; how does this happen?

**Prompts:**

Who does it-MDT/nursing/mixture?

What part does risk play in these decisions?

How accessible are members of staff from each discipline?

- Is there anything that you would like to change about MIETS?

- Is there anything that you would like to add on any of the topics we have spoken about today?

**Information Sheet**

You have been invited to take part in a piece of research forming part of a student study into staff perceptions of the atmosphere on the ward and what it is like to work at MIETS . In order to achieve this, you will be asked to take part in a one to one interview with the researcher to talk about your own experience of working at MIETS; what it is like to work with this client group and within a Multi-Disciplinary Team.

The interview will be recorded using tape recording equipment so that the content can be transcribed and analysed by the researcher. During transcription your name and any other identifying information will be removed so that anonymity can be maintained. The tape recordings will be stored securely in a locked filing cabinet accessible to only the researcher. The recordings and transcriptions will be kept in line with British Psychological Society (BPS) guidelines and will then be destroyed.

You will be asked to read and sign the consent form before taking part in the interview. It is expected that the interview will take no longer than one hour. Should you wish to stop the interview at any time then you are free to do so without incurring any penalty.

The responses that you give will be used to establish potential areas for service development and improvement. The information that you provide will **IN NO WAY** be used to evaluate your performance at MIETS and will not affect your job status or security. Should you wish to withdraw consent to participate at any time, you are free to do so without incurring any penalties and without having to give a reason. Your decision to withdraw will be kept confidential and will not be communicated to anyone else e.g., managers/supervisors/colleagues.

All the data that is generated from your interview will be stored securely and will be accessible only to the researcher. However, the results may be published in psychological journals or reported to other scientific bodies but anonymity will be maintained and you will not be identified in any such publication or report.

Following completion of the research all staff will be invited to attend a presentation of the results and be able to ask questions about the findings.

This information sheet has intended to provide all of the details of the research study that you have been invited to participate in. However, should you have any further questions, please do not hesitate to contact me and I will be happy to answer any queries: [REDACTED]

A list of useful resources has been attached to this information sheet, should you wish to talk about any aspect of the research.

Anna Martin (Researcher)	[REDACTED] or [REDACTED]
Academic Supervisor Supervisor/Line Manager	[REDACTED] via email, phone or in person on the unit.
[REDACTED] (Consultant Psychologist)	[REDACTED]
Unit Manager	[REDACTED]
Human Resources	[REDACTED]
Union Representative	If applicable
Occupational Health	[REDACTED]
Staff Support (Staff Counselling Service)	[REDACTED]
Research and Development Department	[REDACTED]

I would like to take this opportunity to thank you for taking the time to read this information and consider participating in this research study.

Anna Martin

Consent Form

I consent to participate in the research, forming part of a student study, conducted by Anna Martin a Counselling Psychologist in Training in the department of Psychology at City University, London. The research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society (BPS).

The purpose of the study is to gain insight into staff perceptions of the atmosphere on the ward and what it is like to work at MIETS. The results will be used to establish potential areas for service improvement. I understand that the only requirement will be for me to take part in a one to one interview with the researcher that will take no longer than one hour.

I understand that the interview will be tape recorded and then transcribed to allow for data analysis-all tape recordings will be destroyed after transcription. During transcription, any names and identifying information will be removed to protect my anonymity. I understand that all tape recordings and transcriptions will be stored securely in a locked filing cabinet accessible only to the researcher. These recordings and transcriptions will then be destroyed securely in line with BPS guidelines.

I understand that the results of this research will be coded in such a way that my name will not be attached to the information I contribute and that this consent form will be stored separately to any such data. I also understand that the purpose of the research is to examine groups of people and not one particular individual. **I understand that the responses I give will not be used as a means of evaluating my performance on the ward and that my job status and security will not be affected in any way by the responses I give.**

I understand that the results of this research may be published in psychological journals or reported to scientific bodies but that I will not be identified in any such publication or report.

I understand that my participation is voluntary and that there is no penalty for refusal to participate. In addition, I understand that I am free to withdraw my consent at any time

and discontinue participation, without having to give a reason. I recognise that all information I supply will be stored securely and will only be accessible to the researcher.

If I have any questions about any procedure in this research, I understand that I may contact the researcher at: [REDACTED]

Signed: .....

Name (block capitals):.....

Date: .....

1 copy to be kept by researcher and 1 by participant for their own records.

## Categories and Quotes

### What is Engagement?

#### Relational Elements

Jane: To be able to, the first thing that I think about patient engagement is the first thing. I don't think I personally could engage with them unless they trusted me.

Mary: To me, it's building a relationship with the client. It means being able to respond to them. Having some sort of idea of how they're going to react to different things at different times. It's having a sort of knowledge of what they'd like to do and what's going to affect what they do and how and it means doing things with them.

#### Levels of Engagement

Tom: It's, engaging a patient can be at different levels. In general I think it's, in cases - I mean in any cases it is important but in people who have learning disabilities and as a result might have issues with understanding and consenting to treatments, it's important to, for them to have an assessment at that level, to what extent they can actually understand and can contribute and where possible, when they are able, then their engagement should be sought from the very early stages...

Angela: Yeah and do we keep encouraging people to engage in something because I think there's a real drive and I think everybody really wants to get someone to do something but it's checking whether we're starting to push them too much, it's getting that balance really...

## **Evolving Process**

Angela: well maybe we should sometimes just let them say no and respect that and you know, that's probably more important that they're able to say no than to just come to something. So we can show that they did engage in, you know with us for an hour but actually it's not something they wanted to do so they're not gonna learn anything by it, it's not gonna benefit them, it's something that becomes quite negative.

## **Social Worlds/Arenas Map**

Mary: Yeah you've got the managers upstairs, psychologists, psychiatrists, OT's, social workers; they are up there with their own lovely offices. OK and down here, we share one office. We share one office with, well up to eight staff at a time. Which makes it more tricky and you've got, you know three computers amongst six or seven staff say, all wanting to use them at the same time and I think that shows almost like a sort of disrespect, whereas the people upstairs will have their own desk with their own computer.

Angela: Yeah. It does feel like there's a real split sometimes between the nursing staff on the ward and the people that are in the offices upstairs and sometimes get the feeling that it's just two separate entities and we come along and we do something nice and then we leave and that's the kind of feeling that and we don't have to deal with the difficult stuff and it just, then that can become a big resentment if it's kind of left unresolved and so I think that gets in the way and just, I think the biggest thing is the frustration about agreeing something and because it's a large team, you say OK we're gonna, particularly when you're working with somebody where you need to be consistent, they haven't had anything consistent in their whole lives and they're gonna be pushed and testing and trying to find out what's going on, maybe presenting different ways to different people, splitting, you know things aren't gonna be necessarily easy for

somebody and then if we're inconsistent, then it just doesn't help the client and makes things even more confusing but also, we get further and further away because you come to an agreement and then that's not kept to but it's not talked about why I don't agree so maybe it's just too big a team for one person agrees with something, passes it back, it's Chinese whispers or a different understanding or just not agreeing. So they go and do something completely different.

Tom: There was from what I, I mean it was never really, never discussed as a, in a formal kind of forum that I am aware but it was issues of some staff who were based on the ward or within this space feeling that they were excluded from the office space and that somehow generated an artificial divide between those who had privileges in the office space and those who didn't which is not at all my understanding. When I need to be with clinical area in order to see patients or whatever, then I need to go there but that doesn't mean that I shouldn't have access to the office space.

Irene: I think the fact that certain groups work 9-5. So they come in at 9, they go at 5, they do what they have to do and everybody else has to work around them. So the people who do the shifts and come in at 7, finish in the afternoon, finish at 9 and do night shift, all have to plan their day around the needs of the therapists or whoever else comes in at 9 o'clock and that means the service users do too. There's been a slight shift in some people seeing people after supper time which I think is absolutely amazing because why is it set in stone that people think that they have to work 9-5 just because they're a therapist or they're a social worker or they're a doctor or they're whoever. If we're going for a person centred approach, that's something that might need to change in the future, that actually if we're working for the needs of the service user and for the benefit of them, they might prefer to have a session in the evening. So actually we need to think about these things but I think that's a thing that,

## **What Affects Patient Engagement**

## Separation vs Integration

Mary: It's very fragmented at the moment. You've got two managers that are upstairs that sort of call us to go and see them and take people off the ward for hours or they come down, become very critical and you've got a practice development nurse, you know of this, who's again not around very much. Spends most of the time in their office and we've got a housekeeper who should be right in the centre of the centre of this hub in another office and also she could be anywhere in the unit because she's busy but we need to contact her and we don't know where she is and also you don't do anything or go anywhere without informing this hub so, if a client's gone to a therapy session or they've gone out of the unit or they're having a session, whatever it is, you tell the people in the centre and they just feed it through.

Angela: I think part of it is not understanding that people are taking the time to know what is important and everybody having different understandings of what they think. I think part of it is, as much as I hate to, I really like working in this office and I really like working with the other OT's because it's lovely, it's really nice but I know that actually if we were much more muddled up in how we sat and there wasn't the ward and there wasn't people upstairs and everyone's sitting in their own little discipline. I think we probably would work together better and I hate to say it because it's lovely how it is, but I think...

Tom: It's something that again by definition needs to be done in collaboration with a number of other disciplines. I mean that I think holds true with all treatments but particularly so with this non-drug treatment. For example, you, I would take views of other members of the team on medication that would be most appropriate in each individual case but perhaps the weight of other disciplines in actually designing non-drug treatments is heavier than in medication.

Tom: Yes because I don't think that staff who work on the ground floor shouldn't have access to whatever resources are upstairs. I think that it

should be made available and equally if, I don't know if that's a matter for supervision or whatever, but they are encouraged to actually use the space and approach people as they, who are upstairs and I don't think that it will need any more kind of complex intervention for this to be resolved to be honest

Sandra: Well, yeah, they do and so we're not always aware of what's going on in that sense and it doesn't get fed back to us in any other way. I know I think minutes get put on the email but people don't read minutes of the meetings that they haven't been involved in, I don't think and again, it's time consuming reading a whole load of minutes that you might not or couldn't make head nor tail of because you don't know any of the issues really that were flagged up, you don't know about them. You have to go each month maybe or be already aware of it and because people upstairs talk about these things all the time amongst each other. Do you know what I mean, even in passing it'll get spoken about, you know while they're making coffee, it'll get talked about, you know whereas we're really left out of the loop.

Sandra: But I do get the feeling that people upstairs find it intimidating down here and probably feel that it's not their space down here either. I mean there are some members of the MDT that I've never seen in the nursing office or very, very rarely. I think the nursing office can probably be quite intimidating.

Sandra: That's why it'd be nice to sort of break down those barriers and for people to come a bit more so we all get used to one another's faces, you know and it, as I say it is difficult for us to pull ourselves away. It's a long way to go up there. You go up there for more than five minutes, somebody's shouting and hollering downstairs for you. "Where's" you know, whoever, you know you're needed to do this or you should be around to take a call and you know, invariably you're always gonna be missed when you're upstairs and you're not downstairs.

Sandra: It would be, the structure of the building would be more open planned, you'd have a male side and a female side but it wouldn't be so oppressive. Probably get rid of the middle bit, the courtyard because that uses up too much space and just make that a big lounge area, communal. Then you'd have say the offices downstairs, ward clerk would make life so much easier, a good filing system. The social worker would be based downstairs, the consultants would be in most days, the SHO would know his timetable – he'd be in most days. Our unit manager would be downstairs and accessible. The nurse practitioner would be working alongside us on the ward rather than, yeah 9-5 but with us, you know. Yeah, we would see more people from the MDT on the ward. More psychologists probably doing the odd shift now and again.

Irene: You've got two distinct staff groups, those that work on the male side, those that work on the female side and never the twain shall meet except for various times of the day like if we're going to the community meeting or we're going to the community centre or maybe mealtimes across the hatch, you might see a colleague that you came in with at 7 o'clock and won't see 'til 3. So that lends itself to there being a little sub-culture and communication amongst the nursing team can be quite fragmented I think as a result of that and equally, the stairs, there are huge issues and always have been from me. The upstairs, downstairs bit, you know those downstairs are doing this and those upstairs are doing very little, you know.

Irene: I don't know whether I could call it resentment but certainly people know that they have to shape their day in accordance with the 9-5 workers who work upstairs, who then go away to their office to write up their notes, to do whatever they do and make their phone calls. So then they never have to wait until, particular things have been achieved on the ward to then go and write their notes. So they might have to write their notes, if they're working shifts, after their hours have finished because to access a computer, to have the time to be able to walk away from the floor if you like, to be able to go and do those things, may mean that they do them after time but everybody else has the freedom to walk into the

ward, to walk out of the ward regardless of what the activity is and that I think, would be the thing that would really cheese me off if I was working a shift. Having worked some shifts early on when I first started, I did find that I fell into the behaviour pattern of looking out for people as they came through the door and if I was on working with somebody who was having observations, whether or not it was, you were working with them on a one to one or a two to one. I found my whole day being preoccupied by who was coming to take over from me. So I do know what that feels like and that's a real kind of, I think a huge stressor on people. I think the way that observations are conducted here now are very different to back in that time but I can still remember how it felt when people came into the ward, breezed past you, didn't give you the time of day and they were doing that to me as well.

### **Ambiguity/Mystery vs Clarity/Demystification**

Mary: Well a lot more than that yeah, because I think we do a bit of everything don't we, we're doing a bit of psychology, a bit of OT, a bit of medical stuff, a bit of everything and say what is a nurse's role and a nurse actual role is health rather than illness or education or whatever. We are to get the clients as healthy as we can manage and that encompasses everything from healthy eating to sexual education to giving out the medication to learning how to interact in a group situation but it's a little bit like, almost that we're like jack of all trades and master of none. We are experts in our own field but I don't think we're quite sure what our expertise is... other disciplines seem quite specific, this is my area of expertise but what is yours.

Angela: Yeah. I think we have too many meetings that don't have any purpose, that take up a lot of time. I don't think, I think we assume that we're all working towards the same thing without actually checking it out and it's only when you just start to have a conversation that you think, it's quite shocking. I thought they were thinking the same way but actually they're somewhere completely different and it's not necessarily wrong but if I'm assuming you're thinking one way and you're not, it's never

gonna work. So I think kind of having a better understanding of what, why people are here, what they're working towards and also understanding the different roles because I think there's lots of things that are taken for granted about what people do and maybe actually spending, just, even just spending time with people, shadowing somebody else, so you really understand what they do, rather than assuming, but there's lots of things really. I think there's a real pressure to just churn out and achieve and show things quantitatively, without necessarily having the time to plan. So everything's all about the end result rather than how you get there.

Sandra: Yeah but also it doesn't feel safe to sort of mention it in an open forum always because it would almost feel as if I'm not being very loyal to the nursing team.

Sandra: Yeah and what and when to talk about it or challenge it with people because I mean, it's not clear in the ward round book or in the feedback who made that decision, who came up with that decision. It's always, "the team". So it's a very non-descript, who do you go to if you do wanna challenge it, who are "the team", who made that decision? It's not always the consultant, it could be the social worker, it could have been one of the OT's, it could have been one of the nurses, the nurse there. You know, so it's very difficult for the primary nurse then to sort of think, "I don't agree with it but then who do I speak to about that?" to say "actually!" and same for the patients. I'm sure they feel the same, "who made that decision, who do I speak to about it? I can speak to my primary nurse but the primary nurse doesn't know who made that decision."

Irene: I think less, I think some people find it difficult to know what's happening downstairs but I think it's more of a mystery for the nurses to know what's going on up here. I think some people who work up here have worked on the ward and worked as health care assistants or worked in other roles where they worked on wards. So there's less of a fantasy for them but the fantasy on the ward is very definitely, I think greater

about what goes on up here and I always think that you know, if I need to see somebody, dependent on who they are, you can physically see them quaking if they've gotta come up here to me.

Irene: Oh I, fantasy for me would be that, we would all be downstairs. There'd be no upstairs and that people would work flexibly and meet the needs of the service users rather than 9-5 and that would include weekends of course and evenings and I think that fantasy would be that people would offer to be available on the ward other than just coming to do a session, rather than just going to do a session and leaving and that there'd be a lot more information sharing across the disciplines and so to kind of demystify what people do

Irene: Ward round is the classic example of where particular individuals sit in the room for the whole day and it would appear from the rest of the staff, my view, that the rest of the staff would probably view it as, it's a little secret club where decisions are made that they have no impact on and also, I know for a fact from feedback that I've had, that that's certainly how the service users feel, that it's a little group with the door shut, "you're gonna make a decision about my future or you're gonna give me feedback that says "no change" whatever that might mean. Without any explanation about how you've arrived at that decision" and that's a bit that we know that with person centred care, we have to turn around but we're starting the process of offering teaching sessions to change the thinking and I think that that's gonna be easier for the nursing staff to accommodate because in many respects, they're already doing it, they just haven't given it a name.

### **Poor Communication vs Effective Communication**

Mary: Yes and then we can be left afterwards to sort of picking up the pieces and one of the HCA's did really have a go at one of the psychologists after it happened several times after that session that we ended up with you know, restraining and self harm and stuff like that. It's just, please give us a little brief hand over, what's the mental state of our client, just

a rough, nothing in detail, we appreciate it's confidential but as I say we've been talking about some very painful issues and I think she's a bit upset. So, you know, be aware and he did actually take it on board and has done it since, we've had a handover.

Mary: Yeah just not, we just haven't got the full picture sometimes. Some of things that are happening in some of the sessions finding the time to come up upstairs and reading, you know, one of the clients school histories he's been discharged now and that was really interesting, there were two thick folders of his childhood development but never actually got enough time to go upstairs and wade through it but yeah I mean that's just a logistical thing really that information's kept in separate places

Angela: I think, I think we're all still, although we meet for very long ward rounds and meet for long CPA meetings and there's various other meetings that happen that are supposed to be helping us to work together, I think we're still working very separately and it doesn't feel like the goals that are worked towards and the different disciplines are all joined in a sense. I think we're all doing what we think is the right thing to do. I think, I don't even know what other people's goals are to be honest which, I should and the people that I work more closely with and have better understanding how they work is the people that are much more available anyway to, and more easy to approach and are happy to sit and talk for 5, 10 minutes. So, there's the very, the people that you can kind of have informal conversations with, feels like their goals are much more consistent and you can then say, well I know you work, you know have an understanding of what you're working with in a session with you. So you can say and you'll try and kind of then put it into practical sense when you're out in the community, if you're looking at social skills or personal space and then we'll say, well you know, let's practice that and we can have consistency then but it's really random

Tom: I must say that it's [team meetings] happening less than it used to. Now whether this is a change of ethos or a sign that it doesn't work. I don't

think it is, I mean my personal feeling, I don't think it is a sign that it doesn't work. My personal feeling from team meetings is that I found them helpful. I mean you need to keep a balance between you know, calling a team meeting for trivial things on the one hand but on the other hand, being afraid of calling a team meeting if there are issues that need to be discussed. There is the issue of co-ordinating everybody's diaries around this but we usually find a way round this and in the past we have targeted like times or windows of times that were in between meetings that other people were there anyway, so after the referrals meeting there was a slot that people were usually around and things like that. I think, I do value these type of meetings and I must say I kind of miss them as well because they do give you the extra time that perhaps a ward round or a discussion in the corridor or telephone call don't give you.

Sandra: I think the way the ward is structured causes a lot of problems. You've got the office staff 9-5 who's based upstairs and we have the nursing staff based downstairs and I think that causes a lot of problems in terms of communication. We only have like one main meeting a week where the nursing staff get to meet with the consultants and other members of the team to discuss patient care and that's the ward round and then it's not all members of the nursing team that get to see those people. It would just be mainly the charge nurses that would feedback any sort of problem areas with care to the relevant people ie consultant, social worker etc and they feedback to the charge nurse in that meeting and then that information gets disseminated but as you, I mean, well I think that causes a problem because we don't have the opportunity to meet with them all the time because of this upstairs, you know the structure of the ward and they're not always here, we don't know their timetable, they don't come downstairs and spend any time with us, we very rarely get phone calls. Do things mostly on email which again, not everybody has the time to access emails, not everybody's got access to email.

Sandra: I think if people, all the team spent more time with each other face to face. Which means the nursing staff get/have the opportunity to meet with psychologists more often, you know have that sort of free time to do

that. I'm not talking about in a meeting necessarily, just having that time to, for people to come downstairs and spend time in the nursing office and vice versa, for us to have the time to go upstairs and pass on information face to face, doesn't always have to be in a formalised meeting.

Sandra: So we're kind of left out of the loop, you know in terms of the sort of political stuff that does go on. In terms of like for instance, an example would be, recently we've had problems getting patients in, you know advertising our service if you like because we're a national service nationally but a lot of the nursing staff aren't really aware of those issues. So the pressure that we're seeing or the people that are experiencing upstairs ie you know, consultants are having a lot of pressure and the unit manager etc, we don't feel that or we don't know about it so we don't understand that they might be under a lot of pressure. Therefore, you know, they might put that pressure on us in a different way but we're not aware of the initial stuff that they're going through, if you like. Does that make sense?

Sandra: I just think it's a really huge ward and it's really quite tiring to get around and if you wanna pass on a message to somebody, you've gotta make a call and I just think sometimes face to face interactions are more personal than sort of over the phone or via the email. I think it would be better if everyone was based on the same level, on the same, yeah there'd be more office space downstairs and then that way I think we'd get to meet other members of the MDT a lot more, we'd be communicating better and the services would get to see, you know other people more often as well. I think we'd feel more of a team, an equal team. I'm not saying that just because they're upstairs they're more superior or they get the sense of being more superior. I'm just saying we don't communicate as much as we should. There's a big sort of barrier.

### **Criticism/Devalued vs Acknowledgement/Valued**

Mary: I think all the way up, this sense of disempowerment and frustration.

All the way up from the clients who pass it up to the HCA's or nurses, I don't think the OT's are involved and it's not multi-disciplinary, it's more sort of HCA's, nurses and then managers. It's sort of nurse, manager, constant friction and then I guess the manager's have got people above them who are saying that we should be doing whatever it is and then they face, they face the responsibility, they face losing their jobs as well because you know, we could just be accused of embezzling hundreds of thousands really.

Mary: We are, I mean we're here at 10 o'clock at night putting people in seclusion but that's not happened much recently. The ward has really settled but it does, it can happen, it has happened before and it will probably happen again. So it's just, it's sort of seeing that and having it valued really and I think a lot of that is, not so much the other disciplines but more coming from the managers that what we'd really like is if the manager's came down and said, "you've done absolutely brilliantly this week, well done, you know you organised a party, you did, you coped with all the decorating, you've had, you know a patient kicking off, another patient having an argument, it's all been handled, well done!" Just that simple and it doesn't happen.

Peter: Well it doesn't work very well. I mean the, I think it's to do with levels of knowledge or what people know. I mean I could say that I know my patient, my patients and that what I know is, that I value that but the job is to convey that, to communicate the things that I value to other people, principally the nurses but also other members of the team. So it's not a competition but suppose now I come to think of it, the nurses know lots of things but they don't value it, they don't expect it to be valued by others but in fact they do know things. I suppose what I think happens to that knowledge is that they get caught up in the counter transference from the patients and assume that they don't know things like the patients feel they don't know things, they get transmitted to the staff, nursing staff. So there's a kind of devaluing process, a self-devaluing process goes on.

Tom: There isn't and you're trying, rather than losing it altogether, you try to do that by proxy as it were. So that's where I value the nurses for example, contribution in the ward round, what the patient is like but sometimes or the junior doctors, SHO's, sometimes I do say at the ward round when people are kind of reading out their progress report for next week, which sometimes doesn't make sense because the person can't read their writing or because somebody else wrote it and it's not very clear what they meant. I much more value the kind of person's own contributions in their own words what they feel the patient progress was over the last week and I think that's the kind of stuff that I would have liked to have been kind of witnessing myself but I can't, I just get them second hand really from nurses, junior doctors, OT's.

Sandra: Well it's almost as if we tend to think that anybody that is upstairs is going to be more superior and has that right to make those decisions. We don't feel that we can't challenge them but I guess it's a subconscious thing, we kind of almost assume that, OK that decision was made in the ward round therefore, it's gotta be a good one.

Sandra: No not really. No I don't think it does and I am aware that certain members of the team do not feel safe in any meeting. Like the nursing assistants, they're always very quiet in these meetings and I feel that they probably don't feel confident to make their views known. There are certain people, like [HCA X] for instance that will, you know be quite outspoken but there are certain members of the team I think that don't feel comfortable in talking about issues and challenging things.

Sandra: I don't think it works from the top downwards. I think we get treated that way by our nurse managers. Therefore, you know they're our role models and therefore, I think that's how we, there's that hierarchical system and that's how... I'm not speaking for me because I don't, I hope I don't do that but I do know, I'm aware that some qualified nurses do and then treat their juniors or people like the nursing assistants differently or, yeah don't give them the chance to have their own say or view on something. I think subconsciously you know, the unqualified

nurses feel that way anyway, generally but I mean I've been in some places where nursing assistants are quite empowered, very empowered.

Irene: Yeah and you're implementing the recommendations from other groups. Sometimes they're not implementing their own; they're passing them on to be implemented. So they make the decisions but you're expected to carry it out. That can feel I think pretty powerless.

Irene: Yes and that last changed if you like to say that actually the questions that referrers are asking has changed, the length of time that people are prepared to admit people for has changed, the information that they want back has changed and people aren't geared up to do that and I think people feel, some people feel as though it's a reflection on their work and in actual fact it isn't, it's just about the economics. So I think they feel criticised or some people feel criticised by the constant questioning of the PCT's and that can feel quite daunting. So I think that's muddied the water as well and I still am of the belief that the medical cover that we've got on this ward is not appropriate.

## **Reaction vs Reflection**

Peter: Well, I think nurses feel it the most. I think they very much don't feel supported and I think other groups do. Some groups spend a lot of time supporting each other, you know consultant psychiatrists do, for instance I think psychologists aren't bad at it, I don't know about the OT consultants but I don't see the nurses getting much support other than from each other, there's no formal mechanism and supervision from what I've heard doesn't offer a supportive framework. So I'm not surprised that they have difficulty doing their jobs, engaging the patients because there isn't support for that really.

Angela: When I went not all of them [reflective group] were there, so people were being talked about that weren't there, which is gonna happen but I didn't find it... Yeah and I just sort of then reverted back to coming back to the team and my team and saying, but maybe I didn't give it enough of

a chance, I don't know. It'd be good to have somewhere where you could do that where it was safe and it wasn't just within your own discipline because you're with people that mostly tend to think in a similar way to you, so.

Jane: I don't think that's a major, I honestly don't think that's an issue. My only issue with upstairs is and it's not even from the psychologists actually, is that sometimes it annoys me and it does annoy me, I'm not gonna deny that, is the fact that they see them for an hour a week and then they think that they know better than somebody that sees them for 37.1/2 hours a week and I think they should be more, they say about us being open minded but I also think that they need to be a bit more open minded towards us as well and sometimes you know, if you asked us, maybe, perhaps maybe, once in a while we might know or we might know best rather than think that they know these people and they only see them for an hour a week but that is my only complaint. It is. I think it's very unbalanced, even I said to [Psychologist] he should be working shifts on the ward. I said "[Psychologist] you need to do at least one or two shifts on the ward because you're telling me about [Patient] but you don't really know her, all you see her is for half an hour, once or twice a week" and that's not even on a consistent basis because this week she didn't see him. "You don't see her mannerisms, you don't see the way she portrays herself, you don't see the looks she gives us, you don't see any of that, really you really need to come and just observe the ward."

Tom: I think every discipline does have some supervisory structure so at that level, within discipline level it should be there but in between.....Which is the kind of cross fertilisation benefit that we are, I think missing if we just stick to our own discipline. There is team work as well but not at that kind of reflective/emotional type of level.